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ABSTRACT

Papers collected in this volume were prepared for and presented at a conference designed to (1) develop improved information on the status of women as health care providers in the United States and selected countries and (2) provide for consideration by an international audience, strategies used in other countries to improve the status and participation of women as health care providers which might be adapted for use in the United States. Topics include approaches to correcting the underrepresentation of women in the health care professions; improving the utilization of women in health occupations in which they are numerically well represented; organization of nurses and allied health and support personnel; new roles for women in health care delivery; and the role of women in health care decisionmaking. A list of conference participants provides their professional addresses. Summary viewpoints of some conference participants reflecting the needs of women health care workers and consumers are included along with a copy of the conference program. (LAS)

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PROCEEDINGS OF THE INTERNATIONAL CONFERENCE ON WOMEN IN HEALTH

ED134794

JUNE 16–18, 1975
Washington, D.C.

Sponsored by
Health Resources Administration

DHEW Publication (HRA) 76–51
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Resources Administration
Bureau of Health Manpower
Division of Medicine

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Foreword

The papers collected in this volume were prepared for and presented at the International Conference on Women in Health held in Washington, D.C. on June 16–18, 1975. In addition to these papers, videotapes of the Conference proceedings are available for use by the Regional Offices of the Department of Health, Education, and Welfare and other appropriate organizations as background material for discussions in regional or other meetings. The Conference photographic exhibition, "American Women at Work in Health Careers," is also available on loan upon request to the Health Resources Administration. Copies of the Conference chart book of statistical data on the status of women in health careers in the United States and other selected countries are also available upon request.

The Conference, an International Women's Year activity sponsored by the Health Resources Administration, was designed to (a) develop improved information on the status of women as health care providers in the United States and selected countries; (b) present, for consideration by an international audience, strategies used in other countries to improve the status and participation of women as health care providers which might be adapted for use in the United States. The Conference brought together outstanding investigators from countries where women play a major role in the health professions and from countries where research has been conducted on the relationship of various societal factors to the status of women.

The topics covered by the international investigators and U.S. discussants' comments, included the current status of women as health care providers in the United States and selected other countries; approaches to correct the underrepresentation of women in the health professions; improving the utilization of women in health occupations in which they are numerically well represented; organization of nurses and allied health and support personnel; new roles for women in health care delivery; and the role of women in health care decisionmaking.

The highlights of the Conference presented by Dr. Mary Howell (page 169) summarized Conference papers and discussions. It was originally planned for Dr. Howell's summary to be followed by a panel discussion on the future role of women in health in the United States. Congresswoman Martha Keys was to join members of the Conference Steering Committee for the discussion. However, many of the participants requested more time for open discussion from the floor and an opportunity to present more questions to the international investigators. The agenda was modified to permit this greater participation of the audience, and after Congresswoman Keys' presentation, the floor was opened for general discussion. Members of the Steering Committee joined with the international investigators in the discussion period. Their remarks are also included in this publication.

The Conference was closed with an address by the Honorable Francoise Giroud, State Secretary for the Condition of Women in France, who analysed the untapped potential of women health workers for increased contribution to health services in France.

The papers presented were scholarly and provocative. The prepared responses were thoughtful and, for the most part, focus on either the applicability of the information presented to the U.S. situation or on a comparison of the U.S. situation with that in other countries.

A few particular points should be noted:

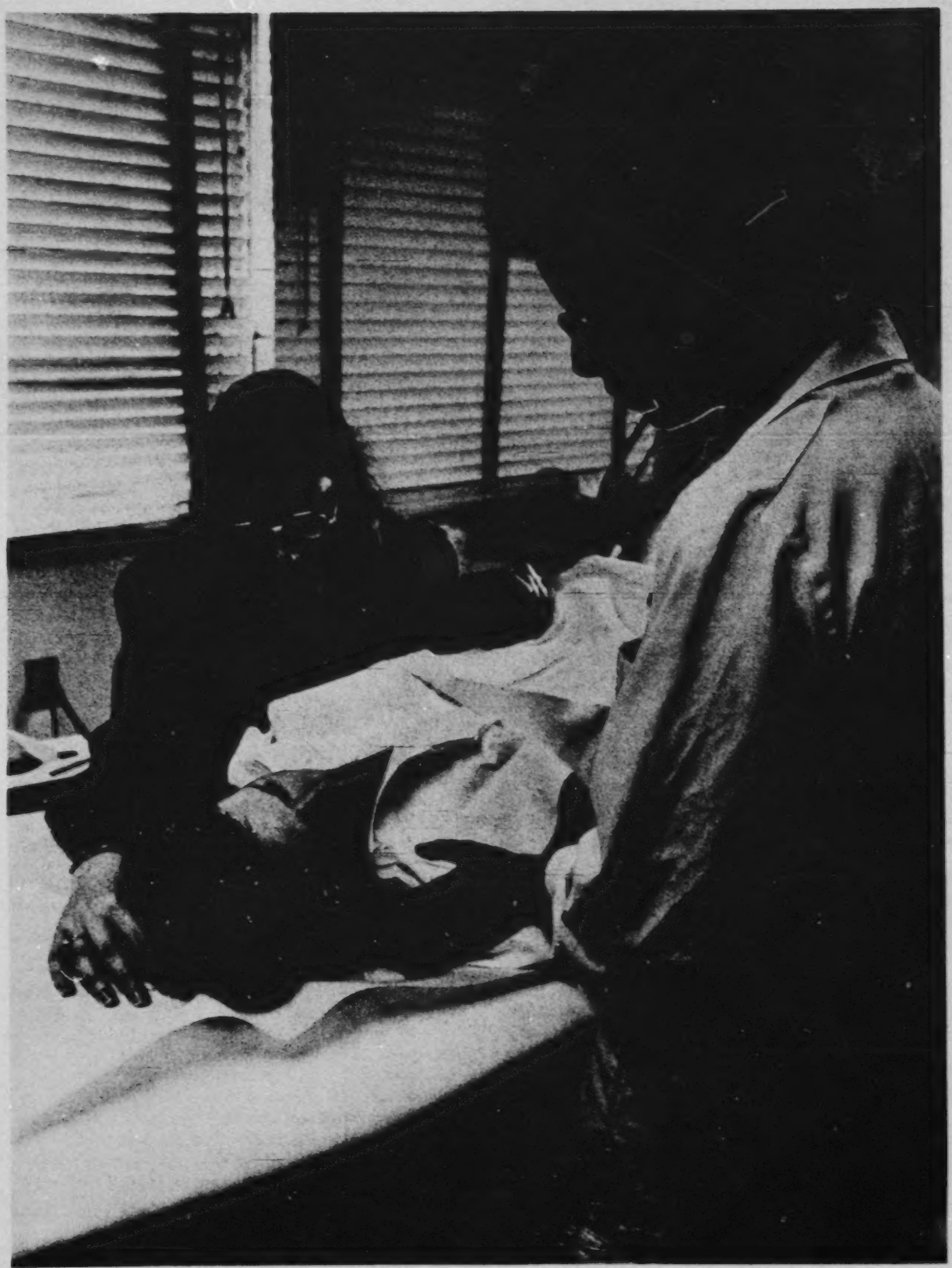
Some of the responses, and much of the participant discussion, were concerned with issues broader than the status and role of women as providers of health care. Concern was expressed about the status and working conditions of both men and women non-professional health care workers, especially those in unskilled jobs such as laundry workers and janitors.

Some attention was paid to the quality of health care delivered to women in the United States. The women who spoke were providers of health care; nevertheless, as women they expressed dissatisfaction with the care that the health care consumers receive. A number of these issues are addressed in the list of specific recommendations prepared by a group of participants in the Conference (Appendix A).

Some participants voiced criticism of physicians as the dominant profession in the current (U.S.) health care system and others even objected to the fact that men (physicians!) had been involved in the planning and program of the Conference. There were others who disagreed with such criticism and felt that change must be effected by working with and within the system and that women can and must work with men in order to bring about those changes. Those participants would answer the question that Madame Francoise Giroud presented at the close of the meeting with "We do not want merely to take men's places, act as they do, or be the dominant rather than the dominated, but indeed we do want to transform society."

Although there certainly was not agreement among the participants as to the major issues of the Conference, the Conference itself provided a much needed forum for debate, and highlighted the need for more opportunities for women, as the great majority of providers and the largest number of consumers of health care, to have a greater role in the decisionmaking process. A Chinese proverb states that "The journey of a thousand miles begins with the first step." If the recommendations prepared by the Conference Steering Committee, based on the results of the Conference (page 187), are recognized and acted upon, perhaps the Department of Health, Education, and Welfare's International Conference on Women in Health and these papers presented there will be that first step.

Betty A. Lockett, Ph.D.
Project Director
International Conference on Women in Health



Conference Steering Committee

Betty A. Lockett, Ph.D.
Conference Project Director, Division of Medicine/BHM/HRA

Darla J. Schecter
Assistant Conference Project Director, Division of Medicine/BHM/HRA

Barbara Kivimae
Division of Planning/OPEL/HRA

Maggie Matthews, Dr.P.H.
Office of Health Resources Opportunity/HRA

Jessie Scott, R.N.
Assistant Surgeon General, Director, Division of Nursing/BHM/HRA

Barbara Ehrenreich, Ph.D.
Associate, Women's Health Forum, New York

Mary Howell, M.D.
Assistant Professor of Pediatrics & Associate Dean for Student Affairs, Harvard Medical School

Vicente Navarro, M.D.
Associate Professor of Medical Care and Hospitals, John Hopkins University

George A. Silver, M.D.
Professor of Public Health, Yale University

Jeanne Spurlock, M.D.
Deputy Medical Director, American Psychiatric Association.

International Advisory Panel

Margot Jefferys, Ph.D.
Professor of Medical Sociology, Bedford College, England

Magdalena Sokolowska, M.D.
Professor of Medical Sociology, Polish Academy of Sciences, Poland

Teresa Orego de Figueroa
Consultant, Pan American Health Organization

A. Petros-Barvazian, M.D.
Chief, Maternal and Child Health Division of Family Health, World Health Organization

Sumedha Khanna, M.D.
Chief, Planning & Evaluation Unit, Department of Family Health and Population Dynamics, Pan American Health Organization

International Conference on Women in Health

Sex Roles in the Health Sector

Monday June 16, 1975

8:30 am-9:15 am	Registration	
9:15 am-9:30 am	Opening Remarks	*Betty A. Lockett, Ph.D.* Conference Project Director and Chief, International Programs Staff, Division of Medicine, Bureau of Health Manpower, Health Resources Administration/PHS
9:30 am-9:45 am	Official Welcome	*Kenneth M. Endicott, M.D.* Administrator, Health Resources Administration/PHS
9:45 am-9:50 am	Introduction of Honorable John G. Veneman	*Theodore Cooper, M.D.* Assistant Secretary for Health/PHS
9:50 am-10:10 am	Remarks on Behalf of President Ford	*Honorable John G. Veneman* Counsel to the Vice-President, Former Under-Secretary of DHEW
10:10 am-10:40 am	Coffee Break	

I. Definition of the Problem: State of the Arts

10:40 am-11:25 am	Status of Women as Health Care Providers in the U.S.	*Barbara Ehrenreich, Ph.D.* Author and Associate, Women's Health Forum New York, New York
11:25 am-12:00 pm	Status of Women as Health Care Providers in Selected Countries	*Margot Jefferys, Ph.D.* Professor of Medical Sociology and Director of Social Research Unit, Bedford College London, England
12:00 pm-1:30 pm	Lunch	

II. Approaches to Correct the Underrepresentation of Women in the Health Professions

1:30 pm-2:30 pm	**A Look at the USSR**	
1:30 pm-1:45 pm	Summary of Research Paper:	*Maria D. Piradova, M.D.* Chief Editor of Health Moscow, USSR

x	1:45 pm-2:10 pm	U.S. Discussant:	*Mark G. Field, Ph.D.* Professor of Sociology, Boston University; Associate of Russian Research Center, Harvard University; and Chairman, Research Committee on the Sociology of Medicine, International Sociological Association Boston, Massachusetts
	2:00 pm-2:15 pm	U.S. Discussant:	*Jean E. Campbell, D.D.S.* Practicing Dentist and Past President of Association of American Women Dentists Placentia, California
	2:15 pm-2:30 pm	General Discussion	
	2:30 pm-3:30 pm	**The Scandinavian Experience**	
	2:30 pm-2:45 pm	Summary of Research Paper:	*Elina Haavio-Mannila, Ph.D.* Professor of Sociology, University of Helsinki, Finland
	2:45 pm-3:00 pm	U.S. Discussant:	*Estelle Ramey, Ph.D.* Professor, Department of Physiology and Biophysics, Georgetown Medical School Washington, D.C.
	3:00 pm-3:15 pm	U.S. Discussant:	*Randi Tillman* Second Year Dental Student University of Pennsylvania Philadelphia, Pennsylvania
	3:15 pm-3:30 pm	General Discussion	

III. Approaches to Improve the Utilization of Women in the Health Occupations in Which They Are Well Represented

3:30 pm-4:30 pm	**How to Improve the Utilization of Nurses and Allied Health and Support Personnel: The Swedish Model**	
3:30 pm-3:45 pm	Summary of Research Paper:	*Inga Johnsson, R.N.* Assistant Head, National Board of Health and Welfare, Planning Unit Stockholm, Sweden
3:45 pm-4:00 pm	U.S. Discussant:	*Loretta C. Ford, R.N., Ed.D.* Dean and Director of Nursing, University of Rochester Rochester, New York

4:00 pm-4:15 pm	U.S. Discussant:	*Elizabeth Harding, R.N., M.S.* Assistant Professor, School of Nursing, University of California San Francisco, California	xi
4:15 pm-4:30 pm	General Discussion		
6:30 pm-8:00 pm	**Reception** National Academy of Sciences The Great Hall South Side of 2100 Block of C Street N.W. Washington, D.C.	*Host:* *Honorable Caspar W. Weinberger* Secretary, DHEW	
8:00 pm-10:00 pm	**Dinner** Department of State Benjamin Franklin Room 2201 C Street, N.W. Washington, D.C.	*Guest of Honor:* *Honorable Francoise Giroud* State Secretary for the Condition of Women, France	

Tuesday, June 17, 1975

8:30 am-9:00 am	Registration	
9:00 am-10:00 am	**Approaches to the Organization of Nurses and Allied Health and Support Personnel: The Australian Experience**	
9:00 am-9:15 am	Summary of Research Paper:	*Mary E. Patten* Federal Secretary, Royal Australian Nursing Federation and Member, Hospitals and Health Services Commission Melbourne, Australia
9:15 am-9:30 am	U.S. Discussant:	*Virginia S. Cleland, R.N., Ph.D.* Professor of Nursing and Director of Graduate Studies, Wayne State University Detroit, Michigan
9:30 am-9:45 am	U.S. Discussant:	*Lillian Roberts* Associate Director for Organization for District Council 37, American Federation of State, County and Municipal Employees, AFL-CIO New York, New York
9:45 am-10:00 am	General Discussion	
10:00 am-11:00 am	**Innovations in the Utilization of Nurses, Allied Health and Support Personnel: A Look at Colombia**	
10:00 am-10:15 am	Summary of Research Paper:	*Maricel Manfredi, R.N.* Director, Department of Nursing, University of Valle Cali, Colombia
10:15 am-10:30 am	U.S. Discussant:	*Ruth Roemer, J.D.* Researcher in Health Law, School of Public Health, University of California Los Angeles, California
10:30 am-10:45 am	U.S. Discussant:	*Ellen T. Fahy, R.N., Ed.D.* Dean and Professor, School of Nursing, State University of New York at Stony Brook Stony Brook, L.I., New York

10:45 am-11:00 am	U.S. Discussant:	*Ruth Watson Lubic, R.N., M.S., C.N.M.* General Director Maternity Center Association New York, New York	xiii
11:00 am-11:30 am	Coffee Break		

IV. New Roles for Women in Health Care Delivery

11:30 am-12:30 pm	**Conditions in China**	
11:30 am-11:45 am	Summary of Research Paper:	*Ruth Sidel, M.S.W.* Author & Lecturer. Books on China: *Serve the People, Women and Child Care in China,* and *Revolutionary China.* New York, New York
11:45 am-12:00 pm	U.S. Discussant:	*Carol A. Brown, Ph.D.* Assistant Professor, Department of Urban Studies, Queens College, CUNY Flushing, New York
12:00 pm-12:15 pm	U.S. Discussant:	*Helen I. Marieskind, M.P.H.* Assistant Professor, Department of Urban Studies, of New York, College of Old Westbury Old Westbury, New York
12:15 pm-12:30 pm	General Discussion	
12:30 pm-2:00 pm	Lunch	
2:00 pm-3:00 pm	**The Cameroonian Experience**	
2:00 pm-2:15 pm	Summary of Research Paper:	*Gladys E. Martin, M.D., M.P.H.* Associate Professor in Community Medicine and Pediatrics, University of Yaounde Yaounde, Cameroon
2:15 pm-2:30 pm	U.S. Discussant:	*Mary Ann Lewis, R.N.* Project Director, PRIMEX/Family Nurse Practitioners Project, University of California Los Angeles, California
2:30 pm-2:45 pm	U.S. Discussant:	*Jacqueline J. Jackson, Ph.D.* Associate Professor, Division of Medical Sociology, Duke University Medical Center Durham, North Carolina
2:45 pm-3:00 pm	General Discussion	

V. Analysis of the Role of Women in Health Care Decisionmaking

3:00 pm-4:00 pm	**A Look at Poland**	
3:00 pm-3:15 pm	Summary of Research Paper:	*Magdalena Sokolowska, M.D., Ph.D., M.P.H.* Professor of Medical Sociology Institute of Philosophy and Sociology, Polish Academy of Sciences
3:15 pm-3:30 pm	U.S. Discussant:	*Nina B. Woodside, M.D., M.P.H.* Director, Center for Women in Medicine The Medical College of Pennsylvania Philadelphia, Pennsylvania
3:30 pm-3:45 pm	U.S. Discussant:	*Judy Spelman, R.N.* Member, Bay Area Negotiating Council San Francisco, California
3:45 pm-4:00 pm	General Discussion	
4:00 pm-4:30 pm	Coffee Break	
4:30 pm-5:30 pm	**A Look at the Philippines**	
4:30 pm-4:45 pm	Summary of Research Paper:	*Aurora P. Asanza, M.D.* Assistant Professor of Pediatrics, College of Medicine, University of the East Quezon City, Philippines
4:45 pm-5:00 pm	U.S. Discussant:	*Betty M. Vetter, M.A.* Executive Director Scientific Manpower Commission Washington, D.C.
5:00 pm-5:15 pm	U.S. Discussant:	*Helen Rodriguez-Trias, M.D.* Attending Pediatrician, Lincoln Hospital Bronx, New York
5:15 pm-5:30 pm	General Discussion	*Conference Room C*
5:45 pm-7:30 pm	**Film Program**	
5:45 pm-6:40 pm	*The Barefoot Doctors of Rural China*	
6:40 pm-6:55 pm	*WOW . . . Women of the World*	
6:55 pm-7:30 pm	*Taking Our Bodies Back*	

Wednesday, June 18, 1975

8:30 am-9:00 am	**Registration**	
9:00 am-9:30 am	Highlights of the Conference	*Mary C. Howell, M.D., Ph.D.* Assistant Professor of Pediatrics and Associate for Student Affairs, Harvard Medical School Boston, Massachusetts
9:30 am-10:30 am	The Future Role of Women in Health in the U.S. Panel Discussion:	*Honorable Martha E. Keys* Congresswoman from Kansas Member of the Committee on Ways and Means, Health Subcommittee *Jessie Scott, R.N.* Assistant Surgeon General, Director, Division of Nursing, Bureau of Health Manpower, Health Resources Administration/PHS *Vicente Navarro, M.D., D.M.S.A., Dr.P.H.* Associate Professor, Department of Medical Care and Hospitals and Department of International Health, John Hopkins University Baltimore, Maryland *George A. Silver, M.D.* Professor of Public Health, Yale University School of Medicine New Haven, Connecticut *Jeanne Spurlock, M.D.* Deputy Medical Director, American Psychiatric Association Washington, D.C.
10:30 am-11:00 am	**Coffee Break**	
11:00 am-11:10 am	Introduction of Closing Speaker	*Honorable Caspar W. Weinberger* Secretary, Department of Health, Education, and Welfare
11:10 am-11:40 am	Closing Address	*Honorable Francoise Giroud* State Secretary for the Condition of Women France
1:30 pm-3:15 pm	**Film Program**	
1:30 pm-2:25 pm	*The Barefoot Doctors of Rural China*	*Conference Room C*
2:25 pm-2:40 pm	*WOW . . . Women of the World*	
2:40 pm-3:15 pm	*Taking Our Bodies Back*	

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Opening Remarks

Betty A. Lockett, Ph.D.
Chief, International Program's Staff, Division of Medicine And Conference Project Director, Bureau of Health Manpower/PHS
U.S. Department of Health, Education, and Welfare

It is my privilege to convene this International Conference on Women in Health on behalf of the Health Resources Administration of the United States Department of Health, Education, and Welfare.

This meeting is not an international conference in one common usage of the word, "international". While this group is together for two and a half days, no attempt will be made to specifically address, on a global basis, important broad concerns about general equity between men and women, the participation of women in societal development, or their common efforts in the cause of peace—these issues are the agenda for the United Nations International Women's Year Conference to be held in Mexico City next week. Rather, our discussions will focus directly on women as providers of health care.

The stated purpose of this meeting is to bring together outstanding researchers who have studied the role and status of women in health careers in other countries—and it is in *this* sense of the word that the conference *is* international.

This group represents more than twelve countries from diverse regions of the world—meeting together to determine what lessons we in the United States might learn from research and experiences in those countries. Clearly, I am not suggesting that only the United States can benefit from this conference—clearly the lessons learned in any given country are potentially relevant for other countries. But we are here to learn from countries other than the United States about methods to improve the status and utilization of women in health and—to hear of the successes and failures of approaches to the problem of sex stereotyping—of men as well as women—in the health field. We also hope to develop information which would permit us to determine the usefulness of possible future cross national comparative research in this area. These are some of the goals which have been set for accomplishment during the time we have together.

After discussing these goals recently with a colleague, he commented to me "You know nothing is ever *really* accomplished with a conference." My immediate reaction to his remark—apart from curiosity about his operational definition of reality—was to mentally list all the objectives we had established for this meeting. I counted the scholarly papers that have been prepared and the statistical data compiled in the conference chart book as tangible outputs already accomplished. 1

However, before I gave a verbal response to his comment, I realized that papers could have been commissioned and statistics compiled without convening an international conference. And I asked myself—what could we hope to achieve with this assembly that could not be accomplished without it—and what can we do to ensure that this conference does not become another shining example of *tokenism* in this area?

I believe there are several qualitative dimensions to the goals of our conference which can best be accomplished by meeting together. First, the meeting allows researchers and health professionals from our country and other countries to engage in dialogue. Written papers are a one-way communication. The conference setting permits two-way communication and this is critical. Research on the status of women and sex stereotyping is still in its early stages—international comparative studies are almost nonexistent. Future research can benefit from the cross fertilization and stimulation that only meeting together and engaging in free and open dialogue produces.

Our discussions and debates can aid in the identification of areas where research and information are needed and perhaps generate new efforts. Exchange of ideas about findings in the papers presented, and the conclusions of our panel on Wednesday morning, also can provide useful information for program planning and policy development within the Health Resources Administration.

Finally and more importantly, this conference was deliberately designed to provide an opportunity for decisionmakers and administrators, as well as researchers, to participate in these discussions and through that participation to become better informed about the status of women in this country in comparison with their status in other countries.

Those of you who are decisionmakers—from the professional organizations, HEW, other agencies of the executive branch, and members of Congress are, for

the most part, men. You will, during this conference have an opportunity to meet with researchers, health professionals, and other health workers, who are for the most part women—women who have demonstrated their ability to articulate and analyze the problems surrounding this issue of the role and status of women in the health field.

Because of the importance of this opportunity, we are most pleased to have with us this morning the government administrators and officials in the audience, as well as the distinguished guests who are our speakers. At this time, I have the personal pleasure of introducing Dr. Kenneth M. Endicott, Administrator of the Health Resources Administration, who will bring to you the official welcome to the conference. It is through the interest and participation of leaders such as Dr. Endicott that the goals of this conference can be realized. Let us all work together these next few days to make a meaningful contribution to the celebration of International Women's Year and cause it to be something more than what Germaine Greer has termed "one long Mother's Day".

Official Welcome

Kenneth M. Endicott, M.D.
Administrator, Health Resources Administration/PHS
U.S. Department of Health, Education, and Welfare

It's a pleasure to open this landmark conference on "Sex Roles in the Health Sector". And it's an honor to welcome the distinguished guests to our country who have already contributed their knowledge, wisdom, and experience in their native countries and are willing to share that collective wisdom with us so that we can do a better job in this country in solving our vast health problems.

I extend a sincere welcome to those of you who have travelled here from all parts of this country to lend your efforts toward creating a system of health care that will be open to all people based on their medical needs as patients or their talents as the providers of high quality health care.

We are here to learn. And we are not afraid to admit that we have much to learn.

For instance, it would be good to learn why we, in this country, consider dentistry a male profession—so much so that only about 2 percent of our dentists are women; and why people in Finland accept a dental profession where more than 70 percent of all dentists are female.

For instance, it would be good to learn how a thirty-eight year old housewife in China can be taught to provide acceptable first line health care with little initial formal training, and how she can embark on a career which includes a regular program of service combined with continuing education.

For instance, I would like to know more about what ingredients make it possible for a country like Cameroon to graduate its first female medical student just this year while raising its percentage of female students now studying in medical school to almost 15 percent. And do we have something to learn from that country which has a career ladder in nursing that gives the appearance of being more systematic than anything we have here?

For instance, what can we learn from the system in the Soviet Union where paid maternity leave, pre-served work status, pre-school establishments, and a system of constant medical attention for children lifts a great deal of responsibility from women allowing them to successfully combine motherhood and careers?

And for instance, what can we learn for *our* future from the way health employee negotiations are handled in Sweden.

These are just some of the subjects with which we will be dealing in the two and a half days ahead of us. And out of this discussion, debate, and clear exchange of ideas, I hope we in this country, and most particularly, we in the Health Resources Administration, will get some new insights into how we can shape our future policies to make the receiving and the providing of health care in the United States a fair and effective experience.

Within the Health Resources Administration, we have programs and people who are looking forward to ways to change our system of health delivery for the better. In the Health Professions and Nursing Training Acts of 1971, discrimination in admission practices in the schools of the health professions and nursing was prohibited. And, in part, the increase in admission rates for female health profession students is testimony to that legislation and the way it was carried out.

When the Health Resources Administration was organized almost two years ago, we established an Office of Health Resources Opportunity to assure equity of access to health care and health careers by all people. Within the past two years, that Office has begun to develop special concerns for programs that affect women and has begun to focus our attention on the problems that women have in achieving equal treatment in the health field.

One far-reaching instrument which we in the Health Resources Administration now have to achieve more effective results in planning for the decent deployment of health resources in communities around the country is the National Health Planning and Resources Development Act of 1974. Within the next six weeks, more than 200 Health Service Areas will be designated and within these areas, Health Systems Agencies will be appointed to plan for the health delivery and resource deployment within those areas. I hope that you will use this new health planning system to take the lessons that are learned at this conference and apply them where appropriate within your local areas. I hope you will continue to be, at state and local levels, spokesmen and women for equality within a quality health delivery system.

Remarks

Theodore Cooper, M.D.
Assistant Secretary for Health/PHS
U.S. Department of Health, Education, and Welfare

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I am delighted to be here this morning on behalf of the Secretary, on behalf of the Department of Health, Education, and Welfare, and on behalf of the United States Public Health Service. I welcome you to this beautiful setting on a beautiful day in a beautiful city.

Dr. Endicott has related to you a broad spectrum of what can be accomplished through a conference such as this and it's follow-through for changing the way we do business in the health field in this country.

In reviewing our own programs in the Public Health Service I am aware that we have not utilized as well as we might a broad spectrum of resources in trying to solve health problems in this country. We also focus on the dollar and we have not taken advantage of the human resource. We have not implemented in an effective way all the activities that could ensure the best utilization of the resources and there are several ways in which we expect to change this.

Dr. Endicott mentioned participation in the planning bill. We will restructure our attitude toward inservice training in the Public Health Service and I could go on to several of the topics which I know will be on your agenda. The message is basically that the Department puts this problem at a high priority. We must learn to utilize more than just the dollar resources, which are now recognized to be finite, for the solution of our health care problems. The leadership which you and overall sectors of society can give to the solution of these problems in health is badly needed because health is now recognized as a top social priority in this country.

Finally, it is reflected in the position that the political system itself will give to the problem of health in the very near future.

Remarks

John G. Veneman
Counselor to the Vice President
of the United States

It is a pleasure to be here this morning to convey to you the warm welcome of The President of the United States. President Ford has expressed his interest in these proceedings, which have brought together officials, scholars, and health professionals from every continent.

During the next few days, the various approaches countries from throughout the world have taken to confront the problems encountered by women in the health professions will be discussed. You will be exchanging experiences, observations, and suggestions. Obviously, all of the positive experiences cannot be applied in each country represented at this conference. But they can tell us what can be done and give all of us some objectives to strive for.

It is appropriate that the health sector be an area on which to focus the celebration of International Women's Year in the United States.

In this country the health industry represents one of the largest elements of our economy. As a vital part of our society, our Government is committed to assuring equal professional opportunities for anyone who pursues a career in this area.

Both the President and Mrs. Ford are strongly interested in seeing that women advance in all professional areas, and that any previous social or institutional impediments do not prove to be a handicap. The President conveys his hope that this conference will provide a significant step toward identifying such impediments and toward developing strategies for removing them.

It is well known that women are the foundation of the health industry and have been since early times. They have always represented the largest numbers, but not proportionately in the upper echelons.

What is not so well known are the contributions that women have made to health, to health policy, and to the field of medicine as a whole.

In this country there were women like Dorothea Dix, who is best known for her campaigns against the horrors of mental institutions and her efforts on behalf of the neglected insane and for her efforts to improve the conditions of jails and penitentiaries. But her great contribution to health services was to establish the first secular nursing service in this country. When the Civil War broke out in 1861, she personally recruited nurses to care for the wounded, and recruited Dr. Elizabeth Blackwell. America's first woman physician, to train them. She then fought the bureaucracy of the Army medical department to gain President Lincoln's appointment as the very first Superintendent of the United States Army Nurses.

A half century after Ms. Dix, Ida Cannon brought medical social work into medicine as an important adjunct of medical care. The emphasis on the patient as a person grew out of her work.

Mrs. Elizabeth Milbank Anderson, whose fortune established the Milbank Memorial Fund, focussed attention on preventive medicine. She propounded in 1913 that she was particularly interested in fostering preventive and social measures for the welfare of the poor of this city. Since that time, more and more of public and private contributions have made their way into support of preventive services.

Dr. Sara Josephine Baker, concerned over infant mortality in New York City, where she served as a health officer at the turn of the century, established clinics which made it possible for mothers to feed their infants clean milk and water and escape the dreadful summer cholera that in August 1904 carried off 40 percent of the babies born that month.

It was Dr. Martha Eliot who convinced the Presidential Committee writing the Social Security Act in 1935 to include a maternal and child health title.

The first concern with occupational health was brought to American medicine by Dr. Alice Hamilton who spent her lifetime contributing to medicine and occupational health.

The list of women who have set or changed the course of medicine in this country goes on and on. Much has been accomplished, but much more remains to be done to remove the barriers that have precluded woman from a fuller participation and achievement in the health fields.

The 1960's in this country were a period of major advances of racial minorities toward removing barriers to social, economic and professional equality in this country.

It appears to me, that the 1970's will be a period of

achieving a new awareness of the potential of our fellow persons to make major professional contributions to society. Throughout the world we are witnessing a significant change in attitudes on the part of women. They have developed a broader base of confidence, awareness and support for their professional potential, and have taken on a new ambition to achieve true professional equality.

Let me turn more specifically to your agenda for the next few days. When I saw the title of the conference, my initial reaction was to ask: is it appropriate to conceptualize roles in the health profession by sex? Shouldn't anyone, regardless of sex, be free to perform any function in the profession? As I mentally responded in the affirmative to those questions another thought came to mind. We should recognize that oftentimes
6 there is a fundamental difference in the way women and men might approach the profession. I believe the feminine style and approach to a specific profession is unique and it can bring a new perspective to that profession. This aspect of the feminist movement may well prove to be a strengthening factor for our society as a whole.

Undoubtedly, much of the data which will be presented in this conference will show significant underrepresentation and underutilization of women in many parts of the health profession and will show that while women may be heavily concentrated in some areas, that they are not adequately represented in other areas of the profession.

It is very difficult to find a woman department chairman in a medical school, or the head of a teaching hospital, or professor for that matter.

The Federal Government has adopted many policies aimed at removing the barriers that stand in the way of achieving equity for women in our society. They have moved aggressively to correct discriminatory practices among institutions of higher learning and professional schools. But it takes a long time to produce results through affirmative action programs.

As I thought about this problem it struck me that the Federal Government unfortunately has only the clumsiest sorts of tools at its disposal to address this kind of a problem. Generally, once the problem has been identified to the government, a Federal agency will move to withhold funding to institutions which encourage any discrimination. The same tool will also be used to provide incentives to change institutional or structural barriers which allow this kind of inequity to continue.

Unfortunately, these tools are slow, they can often be rather easily circumvented, and they are generally not very effective. Change occurs most rapidly when the institutions at issue have already come to realize the inequities and recognize the need for change.

In short, while the Federal Government can remove some institutional impediments by legislation and by going after some of our major social structures with a blunt instrument, it really is not very effective in achieving very major social and personal changes in perception overnight.

This fact lends even more significance to this conference and the upcoming agenda. It seems to me that a more effective tool than the heavy artillery of Federal mandates is through persuasion which can come from strong examples provided by other systems in other countries. Such examples are very effective in breaking down institutional resistance and establishing awareness both on the part of the health industry and on the part of women themselves as to the potential and the value of solving inequities for women in health.

I was impressed to see that every continent is represented at this conference. I think that is very important because only through such broad exchange and discussion can the very best examples be brought out and made more visible and be used to play the role which I have just discussed. I think the approach of this conference is excellent and I am sure it will be very effective.

Let me say personally for myself, and on behalf of the President, that we look forward to carefully studying the reports on these proceedings.

I think it is critical that the information and the ideas generated from your discussions be disseminated widely throughout this country.

The Status of Women as Health Care Providers in the United States

Barbara Ehrenreich, Ph.D.
Author, and Associate
Women's Health Forum
New York, New York

As the first North American speaker I feel obliged to impress upon our foreign guests what a revolutionary step this conference represents, not only with respect to women and their status, but with respect to U.S. foreign policy as well. The guiding principle behind U.S. foreign policy seems to be that the United States has a responsibility to instruct other nations in the correct management of their economic, political and military affairs. It is unprecedented, to my knowledge, for a U.S. governmental agency to call together representatives of other nations, for the express purpose of *learning from them*. I think it is very significant that the idea for such an international conference originated with a group of women within the U.S. Government.

When it comes to the subject of women and health, though, I suppose we have very little choice but to attempt to learn from others. We certainly have very little to teach, except perhaps as a negative example. I can summarize the status of women as health care providers in the U.S. very briefly: It is not good, and it does not look any better by comparison to the situation in other countries. Whether we measure status in terms of income or in terms of more qualitative factors such as control over one's own work, input into institutional decisionmaking, or societal prestige, we find the same thing: Within the U.S. health industry, women occupy jobs characterized by lower income and less power and prestige than those occupied by males in the health industry, and even within the same job category, women receive lower incomes than men. The only exception to this generalization about sex stratification in the health industry occurs in the case of minority group males, who are concentrated at the very bottom of the occupational hierarchy. This pattern of race and sex stratification within the U.S. health industry has been documented again and again—in tones ranging from academic resignation to feminist outrage.[1]

To say that women occupy a subordinate position within the U.S. health industry is hardly to say anything new or startling. After all, women occupy a subordinate position within U.S. industry in general. Women are clustered in low-paying service and clerical occupations, and are underrepresented in top professional and managerial job categories as well as in the skilled crafts.[2] Within any particular industry or industrial sector, one will find an occupational hierarchy grossly parallel to that in health: White males in positions of maximum authority and pay, females and non-white males in positions of minimum authority and pay.

But even against this background of job discrimination and segregation, the situation of women in the U.S. health industry stands out in stark relief, for two reasons: First, because the health workforce is an overwhelmingly female workforce. Approximately 75 percent of this nation's health "manpower", as the expression goes, is actually womanpower.[3] Even by U.S. standards, this represents an unusually high degree of industrial sex segregation. Second, the women in the health workforce are, relative to the bulk of the women in the paid workforce in this country, a highly skilled and trained group. Thirty-two percent of the job categories in the health industry are among those classified as "technical and professional"[4] and even the so-called unskilled jobs frequently involve the on-the-job accumulation of invaluable experience and skill. So it does not take much feminist sensitivity to see that there is something unique about the health industry: Here we have a veritable army of female workers, approximately three million, many of them highly trained and/or experienced, dominated by a tiny cadre (numbering about 400,000) of largely male physicians and administrators.[5]

How do we explain this situation? Let me say at the outset that there is nothing "natural" about it: There is nothing about human anatomy which dictates that males should be physicians and administrators while females should be nurses, technicians and therapists; and there is certainly nothing about human anatomy that dictates that the latter set of occupations should be subordinate to the former. We know that this situation does not prevail in all countries and that it did not always prevail in this one. In the colonial period and the early days of the Republic, women served as autonomous healers—general practitioners as well as midwives—and in some States outnumbered male healers.[6] Ann Hutchinson, the dissident religious leader and founder of Rhode Island, was a general practitioner. Harriet Tubman, the Black leader who led so

many slaves to freedom, worked as both a nurse and a doctor.[7]

It could be argued that there is no mystery about the situation of women in health, that it is simply a reflection of the situation of women in our society in general. There is a great deal of truth to this argument: Certainly the "family" of health workers resembles nothing so clearly as the family itself, with women playing subordinate and nurturant roles, men playing dominant and instrumental roles. The only trouble with this as an explanation is that the modern "family" or health workers is far more authoritarian and patriarchal than the actual American family has been for many decades,[8] especially at this point, with 43 percent of married women working outside their homes.[9] Of course, the medical system "reflects" the sexism prevalent in the society at large (how could it do otherwise?), but it seems also to concentrate and intensify that sexism.

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I would like to argue that what we see in health is a kind of *institutional sexism* which reflects, not just the sexism which prevails in U.S. society at large, but the internal imperatives of the U.S. medical system. For those of you who are new to this country, let me say by way of background that medicine in this country is above all a private business. It is loosely regulated, sporadically subsidized or supplemented by government efforts, but by and large it is left to itself like any other industry within capitalist economy. As a business, U.S. medicine has evolved, in the space of less than 70 years, from what we could call a "preindustrial" phase, characterized by the dominance of the physician as an individual entrepreneur, to what we could call an "industrialized" phase, characterized by a growing centralization of resources in major medical institutions and complexes of institutions.[10] I will argue that the subordination of women has been critical to the success of medicine, as a business venture, in each of these phases.

Women and Health in the Pre-Industrial Stage of American Medicine

Let us look first at the "pre-industrial" stage in North American medical history.[11] Here the American story is very different from that which could be told of most of the European nations. The U.S. had a long history as a relatively underdeveloped colony: There were few university-trained people; and, until very late in the 19th century, nothing that could be called a medical profession. While most European countries had established, university-trained medical professions for centuries, the U.S. had only a large number competing "healers" representing various degrees of training and diverse philosophies of healing. (Actually, until the early 20th century, medical science was not sufficiently developed that university training probably made any difference, anyway.)

The ancestors of today's North American medical profession were just one of the many competing healing sects—a group distinguished by its commitment to a philosophy of healing called "allopathy" and by its demographic composition, almost 100 percent white, male middle class to upper class. It is difficult from today's vantage point to appreciate the difficulties this group, the self-styled "regular" doctors, faced in the 19th century: Not only was there severe competition from other varieties of healers, there was competition within the swollen ranks of the regulars themselves. As a result, the average "regular" practitioner enjoyed no greater income than an ordinary mechanic of the time.[12]

Now I do not want to recount here the interesting story of how that beleaguered sect—the "regular" doctors of the 19th century—became *the* American medical profession of the 20th century: How this group, in alliance with the corporate ruling class represented by the Carnegie and Rockefeller foundations, managed to gain a legal monopoly over the practice of medicine and establish themselves as the most autonomous and highly paid professional group in the U.S.[13] But what I do want to emphasize today is that a great deal, perhaps a majority, of the competition which had to be eliminated was coming from *women*: Women lay healers and midwives, women trained in competing medical sects (which, unlike the regulars, had always welcomed females), and, increasingly in the late 19th century, women seeking to enter the "regular" medical schools. The point is this: The struggle to establish the medical profession as an occupational monopoly and the struggle to oust women from healing roles were, in this country, completely intertwined. Thus we find in 19th century medicine a strain of sexism so virulent that it continues to fascinate male as well as female historians,[14] and which has no parallel in other Western countries.[15] For one example, let me quote Dr. Alfred Stille on the subject of women in medicine in his presidential address to the American Medical Association in 1871:

> Certain women seek to rival men in manly sports . . . and the strong-minded ape them in all things, even in dress. In doing so, they may command a sort of admiration such as all monstrous productions inspire, especially when they tend towards a higher type than their own.[16]

Of course women were not actually ousted from healing roles. At the same time that the emerging medical profession was erecting barriers to the entrance of women, Blacks and working class people; and campaigning for the abolition of midwifery, a new health occupation was taking form—trained nursing. In the late 19th century doctors were increasingly being trained in hospitals. Hospitals needed to be kept clean and orderly; patients needed to be cleaned and fed. Women, at first upper-class women who were outraged by the filthy conditions in American hospitals, stepped in to do the job, and stayed to train large numbers of less affluent women as permanent "nurses". The fledgling nursing profession was made to feel that it was only allowed in on the sufferance of the doctors,

and then only at the price of almost slavish obedience.[17] Even so the doctors felt threatened by their female co-workers. The *Journal of the American Medical Association* reported in 1901 that many doctors found the nurse ". . . often conceited and too unconscious of the due subordination she owes to the medical profession, of which she is a sort of useful parasite."[18]

The formation of the medical and the nursing profession were, in this country, complementary processes. Where there had once been a single generalized "healer", who combined both nurturance and technique, there were now two distinct occupations: one concerned with "caring" and maintenance functions, the other concerned with "curing" and technical functions; one female, the other male. This was a division of labor with immediate economic ramifications: The skills which the physicians appropriated for themselves were those which involved the visible use of technology and science (surgery, the prescribing of medications, etc.) and which could thus be most profitably marketed as commodities. The residue of skills left to the nursing occupation were those with a very low market value, on a par, at the time, with the services of untrained domestic servants.[19] Thus, in a society in which health care was (and remains) a commodity, and where human labor is also a commodity, the price of which determines the social "worth" of any individual, the medical division of labor automatically set women in a situation of vastly inferior status.

Social Forces in the Reproduction of Sex Stratification

The basic pattern of sex stratification was established in this country by about the turn of the century, in what I have called the "pre-industrial" phase of the medical system. Now I would like to take a quick look at some of the social forces which helped to reproduce this pattern until well into the middle of the 20th century.

First, something which again is more or less peculiar to this country, the fact that throughout the 20th century organized medicine has consciously and effectively sought to limit entry to the medical profession, by controlling medical school entrance standards and by lobbying against Federal expenditures for medical education. This policy has affected not only women, but all potential aspirants to medical careers, and has served, until quite recently, to limit medical education to white males of upper middle-class family background.[20]

Second, and less peculiar to this country, is the persistent hegemony of sexist ideology, i.e., the ideology that the social division of labor is determined by innate psychological differences between the sexes: Women are more motherly, therefore, they should take care of children and sick people; women are good at repetitive work, therefore, they should fill the least skilled assembly line jobs; women are indecisive and emotional, therefore, they should not be political leaders, airplane pilots or surgeons; and so on. We have all heard these things many times as we grew up; our lives as women in this and many countries have been shaped by this ideology.

All this is familiar. The only thing I would like to add is that, in this country at least, the medical profession itself has played a significant role in promoting and reinforcing sexist ideology. For example, we find in an 1848 textbook on obstetrics, "She [woman] has a head almost too small for intellect but just big enough for love."[21] For example, in 1877, Dr. Edward Clarke of Harvard Medical College published an influential book in which he proved conclusively that higher education would cause women's uteruses to atrophy.[22] Then, moving ahead to the present, we find in a 1971 textbook on gynecology and obstetrics, the following statement: "The traits that compose the core of the female personality are feminine narcissism, masochism, and passivity."[23]

Or then there was the time, only four years ago, when Dr. Edgar Berman, a former surgeon and advisor to Senator Hubert Humphrey, declared to the press that women are unfit for positions of responsibility because of their monthly "raging hormonal imbalances".[24]

Just two brief comments on this kind of medical sexism. First, note the unabashedly self-serving character of all of these pronouncements. What these doctors are saying, each in his own way, boils down to one thing: Women cannot be doctors. Once again, the ancient fear of female competition: The other thing to note is, that while each of these comments might have been made by the average man on the street (correcting for the medical jargon, of course), they were not. They were made by physicians, who are presumably men of science. In the mouth of a physician, bigotry, superstition and prejudice are all transformed into "scientific fact". Thus the physicians have been in the enviable position of being able to publicly "prove" that their dominance in the health workforce is only "natural".[25]

A final factor I would like to mention in the reproduction of the turn-of-the-century sexual division of labor in health is the failure of our Government to socialize significant parts of women's domestic work—particularly child raising. Throughout the 20th century the U.S. Government has viewed day-care as an emergency measure, as in wartime, or as a service needed only by "problem" families—never as a service which should be guaranteed to all parents who might wish to take advantage of it.[26] Here again, I should mention the role medicine itself has played in making day-care seem unnecessary and even pernicious,[27] although there is no evidence that children raised in high-quality day-care centers are in any way "damaged" or "deprived".[28] At any rate, in the absence of adequate day-care services, women are typically drawn away from jobs requiring lengthy or intensive training, and drawn toward the kind of low-paying, often low-skill jobs which allow for a marginal or episodic relationship to the workforce.[29] (Perhaps the greatest tragedy is the case of those women who must support their families,

with or without day-care, but who, like all other women, are treated as "marginal" employees. This is the case for so many women health workers, particularly in the lower echelon jobs.)

Women in the "Industrial" Stage of U. S. Medicine

So far I have described the origins of women's subordinate status in the "pre-industrial" phase of medicine, and sketched some of the factors which helped to perpetuate that subordinate status in the 20th century. Now let us turn to the contemporary situation, which I have termed the "industrialized" phase of medicine in this country. The "industrialization" of medicine began in the 1930's and accelerated rapidly after World War II. It is a transformation which has been characterized by: (1) The growing institutionalization of the health care delivery system, with hospitals and clinics replacing the solo practitioner's office as major centers of health care resources; (2) A trend toward the centralization of power over local institutions in the hands of a small number of major medical centers.

Thus the health industry has been, in a sense, catching up with the other sectors of U.S. industry: Health care is no longer a "cottage industry" dominated by individual practitioners. The important unit of the delivery system, the major medical center with its network of affiliated facilities, has come more and more to resemble a typical capitalist business enterprise: Though it is usually a legally "nonprofit" enterprise, it does seek to generate a financial surplus which can then be invested in further institutional expansion or in extremely high payments to its top functionaries, the administrators and fully-trained physicians.[30]

In a way, I have exaggerated the extent of "industrialization" of medicine in this country. Most Americans still depend, for their primary care, on individual practitioners, and the American Medical Association, the voice of the individual practitioners, is still one of the most powerful forces in U.S. health policymaking. But for the purpose of analyzing the situation of women workers in health, I have by no means overstated the case. Nurses were hastily drawn into institutional employment during the Depression, when the market for home nursing dried up. Today, three-quarters of the nation's active nurses are employees of hospitals.[31] Even female physicians are more likely than their male counterparts to work in hospital or group settings, in part due to the difficulties women often encounter in setting up their own private practices.[32] For so many of the female job categories—the aides, kitchen workers, specialized therapists and technicians, etc.—there has never been a choice: These jobs exist only in the hospital setting.

So in order to understand the subordinate position of women in health today we must look, for a few minutes, at the organization and nature of hospital work. Today, in the "industrial" phase of medicine, many features of the organization of hospital work are analogous to what one would expect to find in any sector of modern industry:

First, there is an elaborate division of labor. For example, one New York hospital lists 42 pay categories of service and maintenance workers, 35 types of clerical workers, and 38 types of technical and professional personnel. And many of these are still further subdivided into narrow subspecialties.[33] Contrast this to the situation at the turn of the century, when only three categories of workers could be found in hospitals—physicians, trained nurses, and untrained housekeeping aides. What has happened in health is much the same thing that has happened in other industries in the past 50 to 70 years: A progressive replacement of the more costly labor of a multi-functional employee by the less costly labor of a less-skilled employee. For example, many of the original functions of the professional nurse have now been dispersed among a host of more poorly paid employees: Ward clerks, practical nurses, diet aides, operating room technicians, nurses aides and orderlies, etc.[34] Similarly, many formerly physicians' functions have been spun off to cheaper labor: x-ray technicians, clinical laboratory technicians, inhalation therapists.

We should note right away that there has been a definite sexual asymmetry to the process by which labor has been subdivided in hospital work. Professional nursing, stripped of many of its original functions, has been left in an ambiguous and uncomfortable position—threatened from below by the functionally overlapping but cheaper practical nurses, but barred from moving "up" without drastic redefinition of nursing education. For physicians, however, the situation has been totally different. Physicians have spun off fragments of technology as these become routinized (e.g., taking X-rays), but they have also appropriated for themselves each new high-technology function as it has come along (e.g., cardiac catheterization). Nor have the physicians ever relinquished certain functions which, however routine, have symbolic weight in the eyes of the public—for example, surgery of all kinds, communication of medical information to patients. Finally, observe that as cheap labor replaces more costly labor in the health industry, that cheap labor is likely to be female, for the simple reason that female labor is universally cheaper than male labor in U.S. industry.[35]

A second feature of hospital work which finds its parallel in all other industries is the concentration of planning and intellectual work in a group which represents a decreasing proportion of the total workforce. In 1900, for example, physicians alone accounted for 52 percent of the health workforce; in 1970 physicians and administrators together comprised only 12 percent of the total.[36] Yet there has been no dispersion of their power to the growing army of lower-level workers. Physicians and administrators (with variable amounts of input from trustees) make decisions about overall institutional priorities, about the deployment of revenues and capital, about the types of care which will

be offered. The physician himself has, as he has spun off functions, come more and more to play the role of an executive or manager: His "orders" (for injections, medications, lab tests, etc.) determine the work of scores of other workers who are not expected to grasp the intellectual rationale for the tasks they are asked to perform, but only to perform them reliably and repetitively.

These two features of modern hospital work—the minute division of labor and the concentration of the intellectual control of the work in a diminishing proportion of the workforce—are almost universal features of work processes, at least in countries which have followed Western patterns of industrialization. As Harry Braverman has demonstrated in his seminal study of labor in U.S. society, neither of these features of the work process is a "natural" or automatic result of advanced technology. Rather, they are the result of the conscious efforts of management to gain control over the work process, given the fundamental class antagonism between workers and employers in capitalist society.[37] In many industries this "rationalization" of the work process has gone much farther—to the point where the labor of the individual workers is reduced to a single repeated motion or set of motions, and *all* intellectual control of the work process is vested in a tiny elite of engineers and managers. In fact, by comparison to other industries, the work process in health is far from complete: It has been impossible to fully concentrate control of the work process in the hospital's "executives" (physicians and administrators). And, I will argue, it is for this reason that the subordination of women in the hospital workforce—as *women*—persists and flourishes in the modern health workplace.

Let me give just a few reasons why the "rationalization" of the work process in health is necessarily incomplete, at least in those areas directly involved with patient care.[38] First, there is the fact that the work is inherently unpredictable: Patients do not always have coronaries, or babies, on time or in the presence of the appropriate category of health worker. This means that whatever division of labor exists on paper in the personnel manager's office is always vulnerable to the exigencies of the actual work: Practical nurses very often end up doing what registered nurses do; registered nurses very often end up performing tasks legally reserved for physicians, and so on. Second, the nature of the "material" (human beings) means that lengthy prior study is never a guarantee of on-the-job omniscience: The physician may know all about the ionic composition of the patient's blood, but the aide—who does the actual bedside care in most hospitals—may possess equally vital information about whether the patient has eaten that day, or has become depressed, etc. All knowledge relevant to the work process cannot be concentrated in any one functionary, unless that functionary is willing to do almost *all* of the work. Finally, hospital workers are in general highly motivated and committed to their work—at least compared to workers in the many U.S. industries which make useless or destructive products. Most patient care workers have their own understandings of what good patient care is, and many will try to achieve their standards even at the risk of being disciplined for "insubordination".

So health work can never be fully "rationalized" along the lines developed in other industries. So long as the "material" is human beings and not, say, automobile frames moving along on a conveyor belt, it will be impossible to reduce the work to assembly line procedures and it will be impossible to fully separate manual from intellectual effort. What this means is that in the health industry there is a real problem of the legitimization of authority: There are workers who feel that they know more, care more, and actually make a greater contribution to the work than do the managerial level workers—doctors and administrators. There is the nurse who told me, "You could imagine a hospital with no doctors. Everything would be done just the same. But try to imagine a hospital with no nurses. It would be chaos. The patients would all die of neglect." There is the nurse's aide who said that the administrators of her hospital ". . . say they want patient care but they don't make it possible". Or, to look at it from the other side of the fence, there is the physician in a Philadelphia hospital who was so outraged by a nurse's suggestion that he reduce a prescribed dosage of medication that he had her suspended for insubordination—although he had already admitted that the dose she recommended was correct![39] Now that is what I call a crisis in the legitimization of authority! And recall that it is ultimately not only interpersonal authority which is at stake, but the power to allocate money, to determine institutional priorities, and to dictate the conditions of work.

And with this we return to the situation of women in the health workforce today, for I contend that the "solution" to this problem of authority has lain in the sex—and race—stratification of the health workforce. Sex and race stratification make the authority structure seem "natural"—even though it is not justified by the nature of the work and may, in fact, often be *counter*-productive to good patient care. When a doctor speaks to a female underling (and most underlings *are* female), he is not simply one highly trained functionary speaking to another, less highly trained co-worker—he is a *man* speaking to a *woman*. His authority, then, does not need legitimization through superior knowledge, experience, or commitment to service on his part—it is built into the relationship. The relationship between physicians and nurses is particularly highly "sexualized", perhaps because the tensions are particularly high in this case. Student nurses are still advised to use their "feminine wiles" to get their way with doctors; direct suggestions are considered out of order.[40] But sex and race stratification plays a legitimizing role throughout the occupational spectrum, as sociologist Carol Brown writes:

> Much of the "natural" behaviors between occupations turn out to be based on the sex of the incumbent rather

> than the status of the occupation. Male doctors do not treat male subordinates the same way they treat female subordinates . . . Studies of female doctors show that they often try to identify with their occupational authority and are perceived as 'arrogant' in trying to get the same assistance from nurses and other women subordinates that the men get automatically . . . Similar problems arise with a woman chief technician running a partly male department, or a black therapist with white therapy aides. Male orderlies often resent orders given by female nurses. The behavior patterns seen in hospitals between women and men of different occupations are very much sex-status patterns, just as the interpersonal relations between blacks and whites of different occupations are racial relations.[41]

To summarize, I have tried to account for the subordination of women in the U.S. health industry by looking for its origins in the "pre-industrial" phase of medicine, then at some of the social factors which helped to perpetuate the original sexual division of

labor and power, and finally, by looking at the stabilizing role of sex stratification in the contemporary, "industrialized" health industry. A philosophical observation may be in order here: From a distance, the ancient theme of male supremacy and female subordination, which runs through almost all human cultures in one form or another, seems to be as unremarkable and removed from history as the actual physical differences between the sexes. But as we look closer, as I have tried to do in the particular case of health, we find that male supremacy is not just part of the monotonous biological background against which human history is enacted—it takes different forms and plays different roles in different historical circumstances. In the 19th century, the ideology of male supremacy served as an important weapon in the male "regular" physicians' struggle against competing kinds of healers. Today the situation is entirely different: The physicians and administrators, who are essentially co-managers of the health workplace, are sitting atop an ever broader and higher pyramid of so-called ancillary personnel, who are almost entirely female. In this situation, the ancient theme of male supremacy serves a new purpose: It helps to buttress the pyramid and make it seem as if this were the only "natural" way to organize health work.

But things are already changing so fast that I hesitate to put anything in the present tense. Largely due to pressure from the Women's Liberation Movement, medical schools have been admitting more and more women in the last few years. And, in part because of the rising feminist consciousness in this country, women health workers have been showing more and more militance around their own needs and around patient care issues. Nurses as well as other health workers are showing an increasing readiness to organize themselves as workers and, when necessary, to strike or take other job actions to win their demands.[42] With growing numbers of women in medicine and with growing militance among all women in health, sex differences will cease to be the automatic rationale for occupational stratification, and sex *deference* will cease to be a palliative for class antagonism.

In fact, we may be entering a stage where women health workers find that the greatest barrior to change is not so much sexism as it is the hierarchical divisions among women workers themselves. The principle which has led to these divisions—that of replacing costly labor with cheap labor—automatically engenders deep resentments and anxieties. It can lead to a sterile professionalism which uses the banner of "feminism" to advance the status of a particular occupational group, with little or no regard for sister workers in other job categories. But, I think, and here I may be overly optimistic, that there is a growing consciousness of this danger among women in health today: A realization that it is not only the distribution of women within the hierarchy which must be changed, but the hierarchy itself. A realization that it is not only the role of women in the division of labor which is wrong, but the division of labor itself.

I think that that is enough on the status of women in health in the U.S. We have a great deal to learn from our international guests, both those of us who are in positions of power within this country and those of us who are working for change from below. We have a great deal to learn from the industrialized nations whose governments, unlike our own, have taken responsibility for health care planning, financing and organization. We have a great deal to learn from those developing countries which have had to abandon the typical Western patterns of organization of health work, because they found those patterns inconsistent with the optimal delivery of health care to large numbers of people. I should end by telling you that there is one question that will be on the minds of many of us, as North American women, as we listen and learn from representatives of other nations, other cultures, other political and economic systems. And that question is: Can we hope to make the changes we would like to make in the health sector without making much more profound changes in our society? Can we hope for a health care system that is both egalitarian and effective within the context of a social system which is based on class, race and sex inequalities? And if not, if more broad and revolutionary changes are required, then we must ask ourselves—where do we start?

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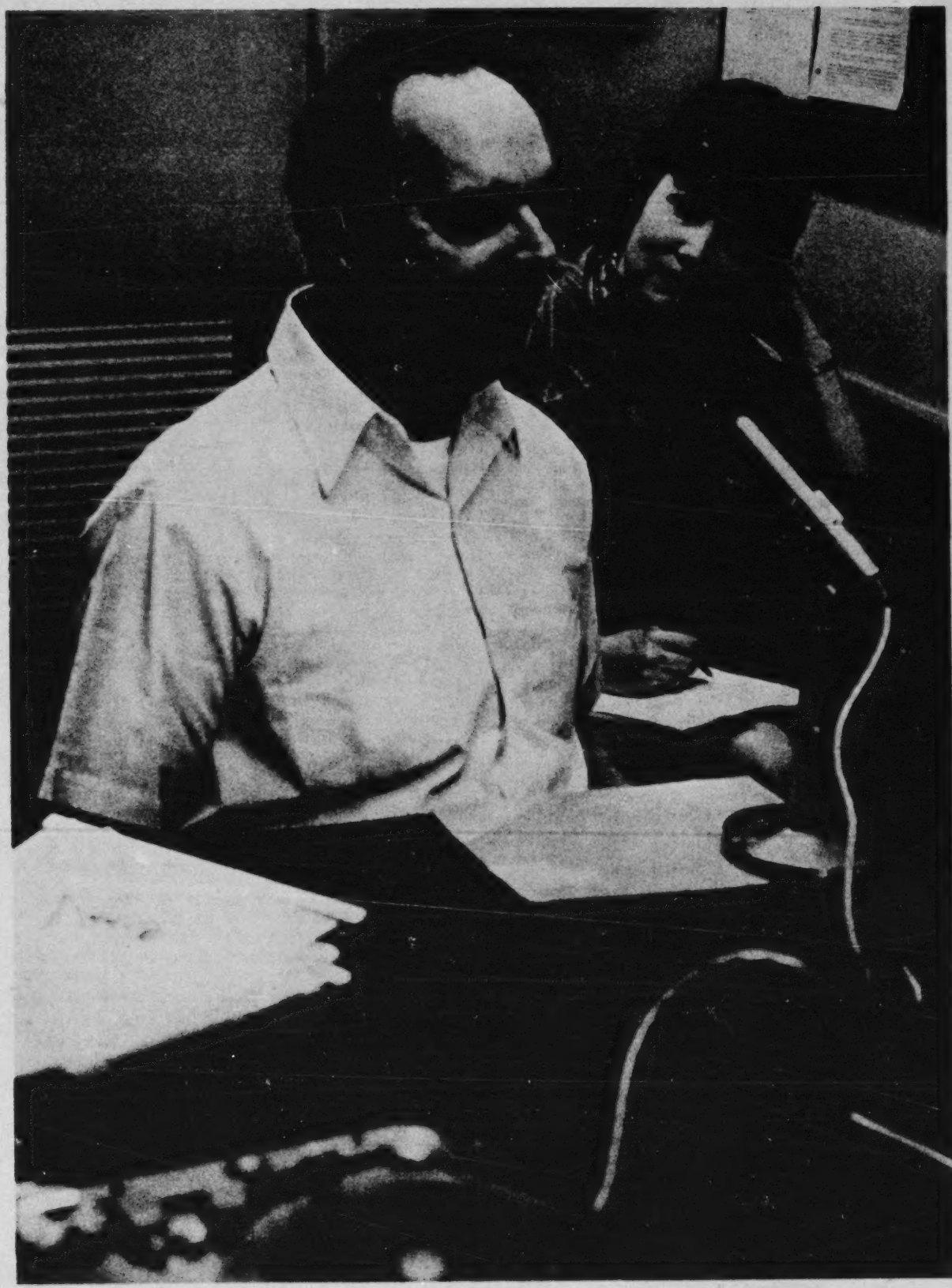

14

The Status of Women as Health Care Providers in Selected Countries

Women in Health: A View From Europe

Margot Jefferys, Ph.D.
Professor of Medical Sociology
and Director of Social Research Unit
Bedford College,
London, England

May I begin by saying how grateful I am to be invited to participate in this international seminar. It is nearly a quarter of a century since my professional interests as a social scientist first brought me into investigations of problems in the health field. Since then I have had the good fortune to meet many women and men who have played a significant part in the planning, administration, monitoring and delivering of health services in their own countries. These interchanges have performed two main functions as far as I am concerned. They have provided me with information about what has been happening in the health services of other countries which I can use to compare and contrast with the experiences of my own country; and they have enriched my personal life with firm friendships. I see this seminar as yet another occasion, and an important one at that, where I have much to gain in knowledge, in insights and in friendships.

Barbara Ehrenreich has provided an analysis of the factors which have affected the part which women are now playing in the health services of North America. My remit is to consider how far the picture she has painted is replicated elsewhere in the world, and, to the extent that it differs, why this might be so.

I can only tackle this formidable task at a rather general level. During the rest of the seminar we will become more specific and focussed. But before I begin I need to put up two general propositions for your consideration.

The first is that we are dealing today with values, that is, with the promotion of policies which many may see as clashing with their accepted systems of values. We are not dealing with absolutes, with over-riding imperatives, but with differing perceptions of the rights and wrongs of promoting certain kinds of activities and relationships and ridding ourselves of others.

The second proposition is that values do not emerge from some superhuman force but are held and promoted by individuals and groups. We have a duty to reveal, not conceal the values which underlie our own advocacy, as well as the values which sustain the policies and practices of others of which we do not approve and seek to change. In other words, we should not be caught pretending that no costs—economic, social and psychic—will be incurred as a result of change. Some people, at least in the short run, will lose out and perceive change we consider desirable as loss. For example, for many women who have accepted and adjusted to the role hitherto assigned them and who find comfort and security in a segregated sex role, it will be disquieting to find that they can no longer rely on the unqualified social approval of their peers and those who through the mass media help to shape public opinion. They deserve empathy from the innovators who, as instigators of social change, acquire the obligation to try to mitigate the distress of those who are the passive victims of historical change, not the arch villains of reaction.

Now let me return to the substantive issues raised by Barbara Ehrenreich. Basically, I believe that her general analysis is right and that the recent experience of technologically advanced industrialised countries, at least in the capitalist sector, parallels to a considerable extent that of the United States. Elsewhere, in both the socialist countries of Eastern Europe and the developing countries of other continents, there are also similarities with the North American situation; but of course there are also certain differences related to such factors as the stage at which a country had access to high technology, to whether or not it is organised on socialist principles, to the extent of the control exercised over its economics by the erstwhile colonising nations and to the fact that at least one of these countries is providing a role model for the development of health services in non-aligned countries in Africa, Asia, South and Central America which differs from that offered by the countries of North America and Western Europe. I do not feel able to comment, except in passing, on developments in these latter countries, so I will consider primarily the use of women as a human health service resource in Western Europe.

It is clear, for a start, that if we take the full range of activities which relate directly or indirectly to the maintenance of physical and mental health, to the prevention of disease and premature death, to the cure of illness and the rehabilitation of the disabled as well as to the care of the sick, infirm and dying, women almost everywhere perform all but a tiny portion of them.

We need to remember, too, that those who perform most of this work are still not paid for doing it. It is done by women in their roles of wife, mother, grandmother and daughter. It is true that there has been a growth in the size and complexity of the labour force working in formal organisations concerned with health —which I propose to examine in a moment—but that growth has only partially been to substitute for the care delivered within the framework of the kinship network. The formally organised health services have supplemented rather than replaced services delivered by women to their kinsfolk. Indeed, because the impact of highly technicalised medical services has been to permit the survival of those who in previous times would not have outlived a massive cerebro-vascular insult, a cardiac infarction or self-inflicted or accidental injury, or a major viral infection, it could be argued that, on balance, there has been an *increase* rather than a *decrease* in the services which kinsfolk are expected to render without direct economic remuneration, however much they may get in the way of psychic rewards.

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This point is worth emphasising, because it serves to underline some of the taken-for-granted assumptions upon which our social life is based. One of these is that only activities for which a payment is made are "work". I have often felt ashamed when, in reply to my question, a woman met at a party or in a plane will say apologetically, "Oh, I don't work. I'm only a housewife", in a totally uncalled-for tone of self-depreciation. I remember one such apologetic woman who had had considerable difficulty in finding someone to replace her for three or four hours once a fortnight in her day-in-night-in task of caring for her highly disturbed, mentally retarded nine-year-old son, and another sixty-year-old single woman who had given up a fascinating job in her mid-fifties to look after her eighty year old parents, one crippled with arthritis and the other senile and incontinent. Incidentally, the latter woman in doing so had forfeited her own pension rights. Nor would she have in her own old age the possibility of an offspring undertaking such a service for her.

The question of how work is rewarded is indeed crucial. In peasant societies in feudal times, income usually accrued to the family unit and was often made up of bartered goods as well as cash. Even in the towns, much productive enterprise took place in the home. Women in most peasant societies had no property, they were themselves, in a sense, the property of their fathers or, after marriage, of their husbands. Their contribution to the productive enterprise was only acknowledged in terms of a share of the goods produced or purchased which they could consume—food, clothing, shelter, and ornament.

As manufacturing left the home for the factory in the industrial revolution of the late 18th and 19th centuries, the new industrialists were eager to employ women and children because, socialised into submission to adult men, they were more readily exploitable. Ironically, the campaigns which took place in the middle of the 19th century to exclude women from the labour market were often conducted by the most prosperous mill, factory, and mine owners, who stood to gain if their smaller, less profitable competitors were driven out of business by their inability to pay the rates paid to adult men by the larger employers. Not unnaturally they were also supported by men seeking to restrict the supply of cheap labour competing for their jobs. It paid both labour unions and prosperous industrialists, as well as landowning statesmen to represent the Factory Acts as humanitarian legislation aimed to cease the double exploitation of women—in and outside the home; and, given the double exploitation, it would be wrong to present their gradual exclusion from many manufacturing trades as entirely a cynical way, covered by liberal rhetoric, of subjugating women to men by restricting their rights to enter the world of work and particularly the skilled trades.

It was not only in manufacturing that the new modes of capitalist enterprise of the 19th century in Western Europe and America created a great demand for labour. The growth of the new capitalist class and a bureaucratic class to administer the large industrial enterprises, as well as the growing volume of business conducted by the State at national and local levels led to the growth of service activities, particularly at the domestic level. Here, there was no campaign to restrict the employment of women and girls, although the convention developed throughout Europe, at a time when differential migration of the sexes to the New World and differential mortality rates were creating a surplus of adult women, that a woman would retire on marriage from paid work outside her domestic hearth, and only re-enter it if forced to do so by penury in widowhood.

By the end of the 19th century in Europe the need for women of middle and upper class, as well as of working class background to find their own means of support through remunerated work was increasing, particularly in Britain. A substantial proportion of adult women could not expect to fulfill the societal norm for women of marriage and support from a husband in return for the performance of the tasks of sexual accessibility, child rearing and domestic management.

It is in this context that the entry of women in large numbers to the growing health sector institutions must be seen. One of the consequences of Florence Nightingale's activities—not entirely unpremeditated—was to make nursing a respectable occupation into which the growing number of middle-class parents would not fear to send their daughters. If the latter were not successful in the marriage stakes, at least they would have the security of a career in a sheltered environment.

It was in this context, too, that women began to beat at the closed doors of the educational institutions responsible for training the medical profession. Throughout Europe the Universities; still nominally Christian foundations if receiving increasing secular

(profane) support from the State, and the bastions of male privilege; were gaining a monopoly in respect of the training of physicians. The more informal systems of training doctors by apprenticeship attachments to apothecaries, although dying out, had also become largely exclusive to males; and women, with the development of technological instrumentation and anaesthesia, were also being ousted from the supervision if not from the care of their fellow women in child birth. As we all know, it took the persistent efforts of a very few brave women in both Europe and North America to break down the barriers; and courage certainly was required to face the often obscene insults flung at them by the backwoodsmen who opposed their admission to higher education in general and medical training and practice in particular.

These patterns of occupational selection laid down firmly in the 19th century throughout Europe have been extraordinarily persistent ever since. Matrimony and motherhood are still perceived as the ideal 'career' for women preceded by work for a few years in an occupation which is oriented to providing personal services (like nursing, or servicing business executives) or to socialising children (like nursery minding or school teaching). Since marriage and child rearing are perceived as women's primary function, any other aspiration must not be fulfilled at its expense, and women who seek to fulfill other ambitions must do so on terms laid down by the employing organisations for the convenience of men who, if they have offspring, have domestic support for them.

It is necessary to emphasise the continuity of societal expectations because, of course, there have in practice been some modifications in the sex composition of health occupations during the last one hundred years. Most of these changes have come about not primarily as a result of successful campaigns by women for greater occupational choice or for the ending of restrictive stereotyping—although these campaigns have, of course, played a part in altering the climate of public opinion about the legitimacy of women's educational and occupational aspirations. They resulted from the needs of the economy for additional labour, particularly during the withdrawal of men from civilian work to the armed forces in the two major wars of this century, and, in more recent years, for reasons which I propose to analyse in a minute.

To take the effect of wars first. In Britain before World War I, there were fewer than 500 women physicians among the 25,000 registered medical practitioners. In 1921, three years after the war, 10 percent of all those in training were women; but this percentage did not rise appreciably during the inter-war years. At the outbreak of World War II in Europe it was estimated that only 13 percent of all medical students and perhaps 10 percent of all practitioners were women. During the Second World War, however, the proportion rose steeply to rather more than a quarter in training and a fifth in practice. Since then these proportions have been consolidated, and not increased until very recently. In other European countries there were comparable trends, although the percentages might differ. In most of Western Europe and Scandinavia the percentage of women was and is lower but is rising rather more rapidly than that in Great Britain, while in the Soviet Union and Eastern Europe it was and is much higher, but is falling rather than rising.

The mechanisms by which only a restricted number of women are admitted to medical training vary from country to country; for example, in Britain, where the medical faculties themselves select students, an informal quota system has been a common device and one which has not appeared too crudely discriminating in practice because the schools can show that women who are courageous enough to apply are no more likely to be rejected than are men, since the demand for admission is so high among the latter. (While no less numerous, the women rejected are better qualified than the men in terms of educational qualifications). In Scandinavian countries and the Netherlands, on the other hand, where the medical faculties *per se* are not entitled to select, it is the Secondary School attainment qualifications in science required which suppress successfully the number of women entering the profession. 17

The mechanisms by which women who do become physicians do not fill the most rewarding posts in the profession in proportion to their numbers—and this seems to be a feature of all European countries—is also a subtle one. Briefly, despite their persistence through the long training period women physicians are not impervious to the social influence of the media and their own reference groups which still persuade them that matrimony and maternity are desirable states and that fulfillment of role obligations in these fields must take precedence over those of the professional field. Hence, at a vital time from the standpoint of post-qualification specialised training, the woman physician who marries and has children is apt to lose out compared with her male colleague. Moreover, despite official rhetoric, little is done to compensate for her disadvantages. Arrangements have been made now in some European countries to enable her to prolong her residency training on a part time basis; but few hospitals make provision for creches and other ways of helping mothers, and still fewer try to reduce the workloads of male staff in order to encourage them to share domestic and child-minding tasks with their wives.

Another effect of the two wars was to suspend the basic norm or presumption that women should not combine marriage with employment. Married women were encouraged to return to employment, and nurseries and creches were established to provide collective care for their pre-school children. These arrangements were phased out after the wars and an attempt made to reimpose the pre-war prohibitions in the public sector on the employment of married women—an attempt which was not as successful after the Second World War as it was after the First.

Incidentally, the ban on married women in local and national government employment in inter-war Britain was supported by single women who saw their married sisters as a potential threat to their own salary levels and promotion prospects. After the Second World War the number of single women and the proportion they formed of all women declined and the ratio of adult males to females began to approach parity. The changes in societal attitudes to the appropriate roles and relationships of the sexes, and in particular women's increasing willingness to assert their rights to equality in marriage and employment, which have been a feature of the last two decades, can perhaps be best related to such objective facts as the more even sex ratio in young adults, the increasing popularity of marriage and the younger age at which it occurs in both sexes, reducing substantially the number of single women available for employment.

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You will see that the gist of my analysis is that the increase in the employment of women which is everywhere apparent in Europe since the end of World War II is largely due to the substantial shift in the employment policy relating to married women and that, while it has been welcomed by them, it was due so much to their pressure on employers in demanding access to work, as to the difficulty met by employers in expanding their labour force in any other way. It is for this reason that women have to re-enter the labour market on terms favourable to men and not to women who retain undiminished their domestic tasks.

One of the fastest growing employment fields in Europe as in the U.S.A. has been the health sector of the economy. Since the Second World War it has been politically expedient for all governments to arrange for easier access to health services, irrespective of an individual's capacity to pay. Britain has financed this access pretty well entirely through central government funds raised by general taxation; other European countries have used various forms of compulsory insurance to which governments and employers as well as individuals contribute. The resulting expansion has almost everywhere taken place mainly in the hospital sector of the health services. Units have become everywhere more complex. Not only does a modern hospital require increasing specialisation of doctors but an increasing number of specialised occupations to carry out the technical side of medical diagnosis and treatment, to maintain the equipment and plant, and to provide nursing care and hotel-type services.

In the full employment which has characterised Europe since World War II, it was difficult for health service units to find sufficient labour to keep pace with the expanding demand. Great publicity has been given to the shortage of doctors, particularly in the remote rural areas or the least salubrious industrial regions; but the shortages of nurses and domestic staff have been often even more acute, resulting in the closure of wards or the early discharge of patients. They have also resulted in the grudging willingness of European countries to provide employment for temporary or permanent immigrants from Third World countries.

One reason for the shortages has been that health services have been reluctant or unable to pay their employees the salaries which could be obtained in other employment. Employers have traded on the assumption that those who work with the sick would not take militant industrial action and would indeed regard that work as a vocation where the satisfaction of helping those in pain would substitute for the crass satisfaction of filthy lucre. Immigrant workers, unable to secure employment or training in their own countries, have been ready to step into the breach. It is they who, in countries like Great Britain, West Germany, France and Switzerland, can constitute as much as a half of all the junior hospital doctor force, and often more than a half of the nurses and domestic staff employed in the hospitals. Not unnaturally, as guests and non-nationals, these folk have been less willing than native born citizens either to organise themselves collectively to bring pressure to bear upon the authorities to improve their salaries and working conditions, or to insist upon a larger share in determining what work they do and how it should be done.

These factors, as well as the traditional view of women—shared unfortunately by many women—as constitutionally less militant and more compliant, have helped to sustain the traditional relationships between the medical profession and the other occupational groups in the health services. Nurses, on the whole, for example, have not challenged seriously the division of clinical work between themselves and doctors and have even been reluctant—perhaps ambivalent would be a better word—to move away from "the doctor's helpmeet" image in order to accept the government proposals that they play a much more important part in the management of health services in and outside the hospital at district level. It is perhaps significant, if somewhat depressing, to find that the nurses and laboratory technicians and oher hospital employees, who have been behind the increasing militancy of the past few years in Britain, are mainly men who are represented on the committees of the Trade Unions out of all proportion to their numbers in the health service.

As you can see, the picture I have drawn of the hospital sector in Europe is not a particularly encouraging one from the standpoint of either increasing opportunities for women or of a more rational distribution of work designed to benefit patients and those who contribute indirectly to the cost of the health services in their role of taxpayer or insurance contributor.

The picture, however, is a little brighter outside the hospital. In Britain and the Netherlands, in particular, the concept of family doctoring and community care, while seriously challenged in the euphoric days of the 1950's when highly specialised technologically sophisticated medicine was thought to have all the answers, has not only survived, but appears to be gaining ground. Indeed, there is evidence that young doctors as well as informed consumers of medical care are

becoming aware of the limits of the specialist services we have devised to deal with our ills and our dissatisfactions. They are suggesting that patients and society in general would benefit if there was a challenge to the trend to "medicalise" more and more of our behaviour and to make the achievement and preservation of social well-being an arcane medical mystery.

In addition, general practitioners are now seeking active collaboration with nurses, midwives, health visitors and social workers to provide a more comprehensive service for their patients. Not all the working arrangements that are made in these teams can be unequivocally welcomed; some appear to be made for the convenience of the doctor rather than for the welfare of patients. Nevertheless, the institutional basis is being moulded for an extension of the role of the nurse and social worker into a domain hitherto the exclusive preserve of the physician; and reciprocally, and not before time, for a broadening of the doctor's understanding of human behaviour.

All the same I cannot feel that Western Europe today is on a sure path to the dual objectives of allowing women to develop their full potential within the health service and of providing a socially responsible service to all its citizens. We have in piecemeal, incremental ways made some progress towards these objectives; but there is still a long way to go, and for accelerated progress to be made we have to rid ourselves of many deep-seated modes of thinking as well as institutionalised rules and regulations. Indeed, I am inclined to think that we have more to learn from the experience of China and other socialist societies than those countries have to learn from us. They, too, rather than us, should be providing the models for the Third World—the developing countries of Asia, Africa and South America, where premature death is still the major problem facing the health services.

Clearly, no country can slavishly copy the provision of another. A graft must always be compatible with its host; but if we want to change the world as well as understand it, we must be bold and prepared to consider ideas that those at the centre of our decision-making institutions are inclined to see as revolutionary and alien.

I hope that this seminar will play its part in enlarging our vision of what is possible and hence our determination to break down those barriers of entrenched prejudice which still prevent women from playing a full part in the promotion of health and the control of their own destinies.

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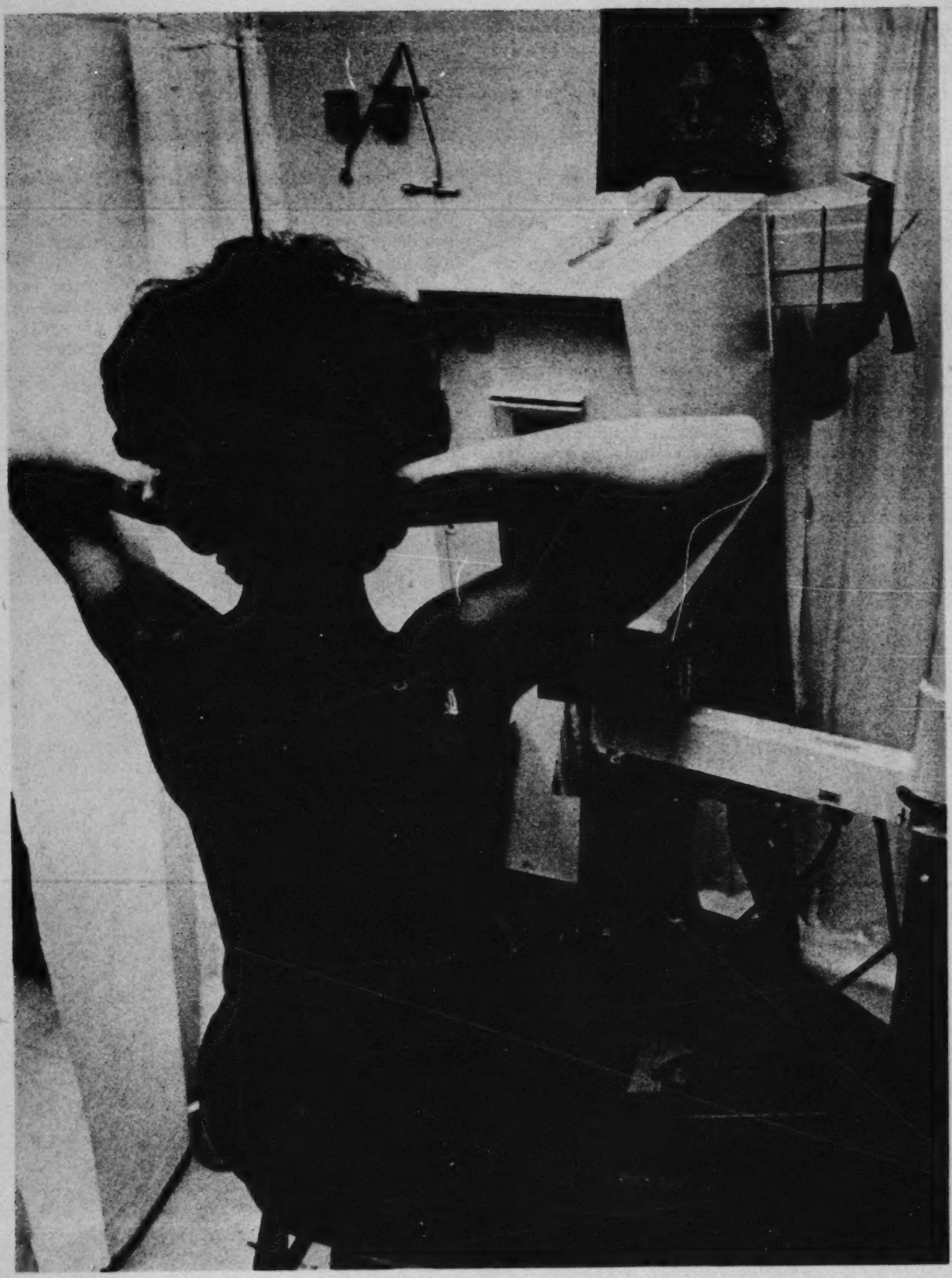


Approaches to Correct the Under Representation of Women in the Health Professions
A Look at the USSR

The Role of Women in the Public Health Care System in the USSR

Maria D. Piradova, M.D.
Chief Editor of HEALTH
Moscow, USSR

One cannot assess adequately the role women play in modern society without a profound long range analysis of economic, social, cultural, national, and historic peculiarities in the development of each country. Women's role in the health care sector (the most humane of all spheres of human activity) is an acute problem with specific peculiarities. But it would be wrong to consider this problem as merely a "technical" one isolated from the general tasks of extending the role of women in all areas of life based on social and economic equality, and providing opportunities so that women would be able to combine their functions as mothers and home guardians with socially useful work.

The health care sector in our country is one of the fields that well reflect the complex struggle of Russian women for their right to play a well-deserved role in society, to utilize their strength and abilities in the noble field of serving the people.

The path to a higher medical education for women in Russia was hard and thorny. The formation of women's higher medical schools dates back to the sharp industrial upswing in the last quarter of the nineteenth century, and was closely linked with the revolutionary democratic movement which brought the most progressive-minded women into its orbit.

The ruling circles were hostile to women's emancipation but, influenced by public opinion, they were forced to partially open the doors of higher education establishments to women. Previously these had been completely closed to women.

On November 2, 1872, "a specialized four-year course for training learned midwives" was opened. On this memorable day, 89 young women crossed the threshold of this shrine of science. History placed a great responsibility on their shoulders for they were pioneers who were to pave a new road for hundreds and thousands of women in Russia. Only those with courage and inflexible will did not fail in the pursuit of their aims.

The first graduates of the course had to go through a lot; they had to overcome social prejudices, the opposition of the authorities and often the opposition of their relatives and friends. They proved to be efficient medical workers and rose to the occasion in the Russian-Turkish war, displaying courage, self-sacrifice and dedication. 21

The following is a quotation from a military medical inspector's report to the commander of the headquarters of the Army in the Field: "The students of the Women's Medical Doctor Courses who were sent to the Army in the Field at the very beginning of the campaign, demonstrated zeal and a conscientious approach to their duties. Delivering surgical and therapeutic aid in hospitals, they came up to the expectations of high medical authorities in this first experience. The selfless work of women doctors in the midst of danger, hardships and typhus (to which many fell victim) drew everybody's attention and it deserves distinction and award as the first instance of the utilization of women in military service."

In spite of the fact that the work of the first women doctors was so highly esteemed, a great deal more had to be done before their activities were officially recognized.

"On February 7, 1878," writes A. N. Shabanova, a graduate of the courses, "the first women doctors were born in Russia *de facto*, but not *de lure:* they came into life without any rights or titles, and not before another five years passed were they put on the list of doctors who were entitled to medical practice in Russia.

"A new *modus vivendi* was in store for them—after their struggle for knowledge they had to begin their struggle for the utilization of their knowledge . . ."

And in this field too, the Russian women gained ground, having proven by their work that they were able to solve the most complicated medical problems and achieve complete success in their profession.

In 1876 the "specialized course" was transformed permanently into "women's medical doctor courses"—the first medical higher education establishment for women in the country. During the fifteen years of their existence they trained and graduated 691 doctors.

In 1897, thanks to the efforts and donations of the progressive public of the country, the Women's Medical Institute in St. Petersburg was founded. This appeared to be a very important stage in the development of women's access to higher education. It was a stimulus for the opening of specialized women's medical higher

education establishments in a number of other cities such as Kiev, Kharkov, Odessa and Ekaterinoslav. Later, women were allowed admission to medical departments at universities throughout the country. In 1913, the number of women doctors totalled 2,800, or 10 percent of all the doctors in the country.

In pre-revolutionary Russia, there were more women doctors than in any other country in the world, but the total number of doctors was not sufficient for elementary health care delivery. Apart from women doctors of Russian and Jewish backgrounds, there were a few women doctors who represented other nationalities: 32 Armenians, 13 Lithuanians, nine Latvians, seven Georgians, three Moldavians, two Belorussians, two Tarters, and one Kirgiz. There was not a single Ukranian woman doctor in the country, nor a Uzbek, an Azerbajahn, a Turkman, a Kazakh or a representative of many other of the more than 100 nationalities in the country.

As to the medium-grade medical staff, their utilization in medical care delivery started as late as the middle of the nineteenth century. In 1844 the Trinity Community, which specialized in training medical nurses, was organized in St. Petersburg. One hundred and twenty medical nurses (who for years and years were called in Russia, the tender-hearted sisters) from the Krestovozdvizhenskaja Community went to Sebastopol, the Crimean theatre of operations. They were headed by the great Russian surgeon N. I. Pirogov. This event may be considered as one of the landmarks of the history of nurse training practices in Russia.

These 120 nurses found themselves in most difficult conditions in the besieged city, but were equal to the situation and selflessly fulfilled their professional duty. Their activities echoed not only in Russia but also abroad, and this fact contributed to the organization of the International Red Cross Society. It also brought about the extension of the nurse training system: from 1875 they were officially put on hospital staffs.

In 1854, women were granted an opportunity to take up a feldsher's profession, which is a category of medical workers peculiar to our country. Feldshers are doctors' assistants who are more competent and trained on a higher level than nurses.

The third category of medium-grade medical staff, midwives, were also trained in specialized schools.

The extension of the health care sector and the growth of the network of hospitals, urged the expansion of medium-grade medical staff training: by 1917 medium-grade medical staff totalled 46,000, nearly all of them women.

Social and economic transformations that took place after the victory of the October Socialist Revolution, radically changed the social position of women in our country. The legislative security of complete equality of women in all areas of political and economic life and the purposeful activities of the state aimed at fully providing these rights, determined the ever-growing role of women in social production, in the development of science, culture and family life.

We were able to do so due to the solution of a number of social problems. Laws were adopted that guarantee protection of women's labour, including maternity leaves and favorable conditions and privileges for expectant mothers before and after childbirth. In our country, paid maternity leaves comes to 112 calendar days, and the mother is entitled to an additional leave until her baby is 12 months old, with her place at work preserved and her continuity of service uninterrupted.

The establishment of the system of constant medical attention for children, the network of children's preschool establishments—creches, kindergartens, extended day classes at school—all these measures lifted a great deal of responsibility from women and enabled them to successfully combine motherhood with creative work. In this respect one shouldn't underestimate the steps taken by the state aimed at building public service establishments, catering facilities, etc.

The health care sector became one of the most inviting fields for women. During the fifty-odd years of the recent development of our country, they have gained a dominant position in this area. This historical experience in Russia was important, for it proved—through women's participation in decisionmaking in Soviet public health services—the adequacy and competence of women in all branches of medicine.

There is no doubt that the decisive factor in the extent to which women in our country were brought into the system of public health services, was the utter reorganization of the health care sector on a totally new ground. Our society became fully responsible for the protection and strengthening of the health of the population.

The single state health care system is free of charge and available to everybody. This fact totally changed the character of the doctor's activity, freeing him of the necessity to secure his financial position at the expense of his patients and thus making his relationships with his patients merely professional relationships.

The organizational form of the work of doctors and mid-level medical personnel has also changed. The establishment of a wide network of out-hospital health care establishments (health centres, out-patient clinics, specialized prophylactic centres, etc.) turned doctors as well as other medical workers into members of one and the same collective, united in a well-equipped medical centre which provided complete utilization of the rich arsenal of diagnostic and treatment methods. The rights and responsibilities of medical workers are precisely regulated and the volume of work and working hours are strictly fixed.

The fixed working hours of a doctor in a hospital (in-patient services) come to 6.5 a day; in a polyclinic (out-patient services only) 5.5 hours a day. The working day of roentgenologists and of some other specialists is limited to 5 hours a day.

Every doctor in our country, in any branch of the

medical profession, has opportunities to consult specialists and more competent colleagues in other branches. They are entitled to all necessary information and to participation in all refresher programs.

There are other factors, of no less importance, that attracted women to the health care sector. These include opportunities for majoring in the field one chooses, for constant creative progress, and fixed wages and working hours. Another factor that caused women's active involvement in this area was an expansion of the system of higher medical education in the country.

In pre-revolutionary Russia, doctors were trained at 17 university medical departments. The annual number of graduates was less than a thousand. The country was very poorly provided with doctors; there were less than two doctors for every 10,000 people.

The health care sector of the young Soviet State experienced an acute shortage of mid-level medical staff. The situation regarding medical personnel was really tragic in national republics, since they had no medical education establishments whatsoever. The task was not only to extend the network of medical higher education establishments, but first and foremost, to establish such institutions in national republics and in remote areas of the country.

During the first five years of Soviet power, 16 new medical departments were opened in the country. Progressive-minded Russian professors and teachers of the leading universities of Russia took an active part in the organization and formation of these departments. In subsequent years, the network of medical education establishments was extended and improved. The opening of higher education establishments in national republics and remote areas of the country, free-of-charge education, and grants for students—all this attracted representatives of the native population and women to the higher schools.

As time went on, women became the main bulk of practical doctors and later, the main bulk of professors and teaching staff of medical institutes (university level) and the medical research institutes which were opened in national republics. Today, there are 92 medical higher education establishments which graduate annually about 50,000 specialists, most of whom are women.

The system of secondary specialized medical education has greatly expanded. There are 656 medical and pharmacological secondary schools with an annual graduation rate of 140,000 (including feldshers, midwives, laboratory technicians and roetgenotechnicians).

The problem of training and continued education of medical personnel was and is most important in the Soviet public health care system. The constantly growing network of curing-prophylactic establishments, polyclinics, consultation centres, specialized prophylactic centres, sanitary-epidemiological stations, etc., the growth of the network of in-patient hospitals (the number of hospital beds in 1973 came to 2,866,000 or 114 beds for each 10,000 people), the extension of the number of health resorts and sanatoria (the number of sanatoria and rest homes in 1973 came to 5,548 with 9,527 beds), the extension of prophylactic work to a certain contingent of healthy and sick people—all these factors demand a constant flow of all categories of medical workers into the public health care sector. At present, over five million people are employed in the Soviet public health services. The overwhelming majority of medical workers, 85 percent, are women.

The number of doctors in 1973 came to 7,667,000 (306 doctors per each 10,000 inhabitants); 5,368,000 are women (70 percent of the total number of doctors). What is worth emphasizing is the fact that in the national republics, where as late as fifty years ago there was not a single woman doctor, today the majority of doctors are women.

Thus, in the Kazakh, SSR women doctors number 70 percent of all doctors; in Armenia, 71 percent; in the Kirgiz Republic, 67 percent; 57 percent in both Uzbekistan and Turkmenia; and in Tadjikistan, 56 percent. 23

The number of mid-level medical personnel in 1973 came to 23,688,000 (94.4 specialists for each 10,000 people).

In 1973, the public health services sector employed: 1,152,000 medical nurses; 5,225,000 feldshers; 243,000 midwives; 995,000 lab technicians; 78,000 feldsher-midwives; 438,000 assistant sanitary doctors and epidemiologists; 292,000 dentist technicians; and 28,000 radiologist technicians.

Among the qualified mid-level medical staff, the overwhelming majority are women—more than 99.5 percent of the nurses and more than 85 percent of the feldshers. Women are also dominant in pharmacology; in 1973, there were 568,000 pharmacologists with a higher education diploma, and 1,336,000 with a secondary education diploma.

It must be said that in the future as well, women will prevail among the medical workers in the Soviet public health sector. This statement may be illustrated with the help of the following figures: in the 1973-74 school year, women comprised 56 percent of the total number of medical students at higher medical schools; and in secondary schools, 88 percent.

Describing the role of women doctors in practical medicine, one should underline a tendency, which is evident in the Soviet public health care system as well as in most countries in the world: A progressive tendency toward the extension of specialization. At present, 51 doctors' specialities are officially recognized in the USSR.

What particular branches seem attractive to women? Before answering this question, we must underline the fact that the choice of a medical profession, as well as further specialization, is determined by the wishes, abilities and inclinations of the would-be doctor.

Every medical institute in our country has a Faculty of Therapy, Sanitation and Hygiene, a Faculty of Pediatrics, a Faculty of Stomatology, a Medico-biological Faculty, and a Faculty of Pharmacy. So every applicant to a higher education institution makes a choice from

the very beginning as to his future activities. Each department has its own specific curriculum and syllabus.

For example, the curriculum of the Faculty of Therapy contains a two-year course of medico-biological subjects, a three-year clinical training, a one-year "subordinatura" course in therapy, surgery, obstetrics and gynecology (in one of the branches of the student's choice). After graduation, a young doctor works for a year in a curative-prophylactic establishment as an intern, mastering one of the above mentioned specialties or a narrower specialty. Later, the doctor is entitled to work in the branch he has chosen, with an obligatory further training; the length of this further training and the volume of work is fixed for every specialty individually.

In the Soviet Union, a state system has been developed on the further training of doctors. They undergo specialization at institutes and faculties of further training of doctors, and in large regional and city hospitals. Doctors who have little or no experience in the branch they have chosen, must take a course of primary specialization. Doctors who have experience in the field, undergo a further improvement of their qualifications at institutes of the further training of doctors. There are 13 institutes of this kind in our country.

The improvement of doctors' qualifications is being exercised also through the clinical two-year "ordinatura" attached to higher education establishments and to institutes of further training of doctors. The teaching and scientific staff for medical institutes is being reinforced mainly through the "aspirantura" system at the medical higher education establishments and research institutes. That's a three-year course.

The survey on the distribution of women doctors in specialties was made in the Russian Federation, the largest republic, where more than 50 percent of all USSR doctors work. The results of the study showed that more than 30 percent of women doctors are specialists in therapy (therapists, infectionists, cardio-rheumotologists, endocrinologists, haemotologists, physiotherapists, gastroentorologists, etc.). Of the total women doctors, 17.7 percent are pediatricians, 9 percent obstetricians and gynecologists, and 6.2 percent stomatologists. Nearly 6 percent of the women doctors specialize in surgery (surgeons, oncologists, traumotologists, orthopaedicians, cardio-vascular surgeons, neurosurgeons, etc.). The survey shows that 3.7 percent of women doctors are phthisiologists, 3.3 percent roentgenologists, 3.2 percent ophthalmologists, 3.3 percent laboratory doctors, 3.0 percent neuropathologists, 2.7 percent otolaringologists, 2.4 percent psychiatrists, 2.2 percent medically qualified sanitarians, 1.9 percent dormatovenereologists, 1.9 percent bacteriologists, and 1.8 percent epidemiologists. Nearly 2 percent of women doctors specialize in public health administration.

The above data, characterizing the professional activities of women doctors, testifies to the fact that a considerable number—over 60 percent specialize in therapy, pediatrics, obstetrics-gynecology, and stomatology.

Branch of Medicine	Percent of Women Doctors
Pediatrician, obstetrician-gynecologist, cardio-rheumatologist, endocrinologist, laboratory doctor, bacteriologist	over 90 percent
therapist, infectionist, ophthalmologist, haemotologist, dietician, physio-therapist	80 percent–90 percent
epidemiologist, neuropathologist, otolaryngologist, phthisiologist, stomatologist, remedial physical culture doctors, ECG doctor, gastro-enterologist, doctor-statistician	70 percent–80 percent
oncologist, phychiatrist, roentgenologist, medically qualified sanitarian, nephrologist, doctor specializing in the health education of the population	60 percent–70 percent
cardio-vascular surgeon, health care organizer, toxicologist, patho-anatomist	50 percent–60 percent
anaesthesiologist-reanimator	over 40 percent
surgeon, traumotologist-orthopaedician, urologist, chest surgeon	30 percent–40 percent

The highest percentage (93.3 percent) of women doctors specialize in pediatrics, the lowest (24.9 percent) in neurosurgery.

Over the last decade, there has been no considerable change in women's specialization in different branches of medicine or within each branch. We may assume that the professional structure of women doctors in our country has stabilized, and we do not expect, at least in the coming decade, increases or decreases.

Women play a considerable role in the development of medical science and training of medical personnel. In pre-revolutionary Russia, there were occasional women among scientific and teaching personnel. During the years of Soviet power, the situation has radically changed.

In 1974, 33,415 women doctors worked in the field of medical science and higher education establishments. That amounts to 51 percent of the total number of research workers and scientific teaching staff at institutes. Of this number, there are: 20 academicians and corresponding members of the Academy of Medical Sciences (10 percent of the total); 1,946 doctors of medical sciences (31 percent of the total); 18,382 candidates of medical sciences (50 percent of the total); 1,028 professors (26 percent of the total); and 12,714 docents (40 percent of the total).

It's worth noting that the share of women researchers and teachers at medical higher educational establishments is larger than the average for the whole country, where the total number of women scientists comes to 40 percent and the number of women doctors and candidates of sciences comes to 14 percent and 28 percent respectively.

Today 42 research and higher education medical

establishments are headed by women. The corresponding member of the Academy of Sciences of the USSR, physiologist Natalya Bekhtereva, heads the Academy's Institute of Experimental Medicine; the Institute of Rheumatism is headed by Valentina Nasonova, the corresponding member of the Academy of Medical Sciences.

The leading academician V. P. Filatov's Institute of Eye Diseases and Tissue Therapy is directed by the Hero of Socialist Labour Academician of the Academy of Science of the USSR, Nadezhda Puchkovskaya. Anastasya Shiskova heads the Research Institute of Hygiene.

Many women scientists have been distinguished by receiving high national awards for their activities. There are many women medical workers among Lenin and State prize winners. These highly esteemed titles are awarded for invaluable contribution to the development of national and world science. These prizes have been given to the following distinguished scientists: virusologist Elena Golinevitch, pediatrician Julia Dombrovskaya, microbiologist Gita Kagan, biochemist Maria Brazhnikova, neuropathologists Alexandra Koltover and Ludmila Bragina, hygienist Elena Vorontsova, virusologist Antonina Shubladze, and hygienists Natalja Tarasenko and Angelina Guskova. Many Soviet women scientists are members of foreign academies and scientific societies.

We don't think that the picture of the versatile activities of Soviet women would be complete if we did not dwell, at least in part, on their role in public health administration. In our country, public administration at all levels, from a rural medical post to the USSR Ministry of Health, is exercised by doctors.

The administrator of any curative institution or public health establishment does not fulfill merely administrative functions but is fully responsible for the quality of curative and prophylactic care, for the security of high standards in the delivery of all kinds of medical assistance, and for the fulfillment of the planned health improvement measures aimed at reducing morbidity and improving health among all population groups.

Through their work, our women doctors have proven their ability to solve the most difficult problems in health administration. The statistical estimations show that the share of women in health administration is increasing. In 1926, 1,200 women headed various curative-prophylactic establishments. In ten years, this number increased to over 6,500, and in 1959, as many as 23,000 women were engaged in health administration. At present, women lead public health establishments at all levels and more than half of the curative-prophylactic establishments are headed by women.

For many years Maria Kovrigina, an outstanding organizer and presently director of the Central Institute of Further Training of Doctors, held the post of Minister of Health of the USSR. Irina Blokhina, director of the Gorky Research Institute of Epidemiology and Microbiology, is also a deputy to the Supreme Soviet of the USSR, heading the Commission of public health care and social security in the Supreme Soviet of the USSR (which is the highest legislative body of our country).

Hundreds of women hold leading posts in the Ministry of Health of the USSR and in ministries of national and autonomous republics. Women head regional, city and district health care departments; they administer large hospitals, sanitary epidemiological stations, dispensaries, ambulance stations, ambulance plane stations, health resort establishments, and medical and sanitary units at industrial enterprises.

Twelve women are Vice-Ministers at Ministries of Health of the USSR and union republics; three women hold posts as ministers of health in autonomous republics, and 48 head main departments and departments at ministries.

Women play a considerable role in the leadership of the medical workers trade union. Nadezhda Grigoryeva, who for many years was Vice-Minister in charge of the protection of maternal and child health in the Russian Federation, is now chairman of the Central Committee of the Medical Workers trade union. The Red Cross and Red Crescent Society in the USSR is headed by Nadezhda Troyan, a woman who distinguished herself in the partisan movement during the Great Patriotic War and was awarded the title of Hero of the Soviet Union.

In this year of 1975 when we celebrate the 30th anniversary of the Great Victory over fascism, we remember the unparalleled heroic exploits of Soviet women medical workers at the front. Thousands and thousands of women doctors, nurses, medical instructors, volunteer nurses and orderlies participated in action and kept their difficult watch in military hospitals. Of the combat units, 21.7 percent were women doctors while 41.7 percent of the doctors in field mobile hospitals and 54 percent in the evacuation hospitals were women. Their military services for their country were marked with high governmental awards. The title of Hero of the Soviet Union was conferred on 17 women medical workers. Scores of thousands of women were awarded military orders and medals of the Soviet Union.

Women medical workers are highly respected in our country. The people and the state appreciate their work. The high title of Hero of Socialist Labour has been awarded to 49 women doctors. The honorary title of "Merited Doctor of the Republic" has been conferred on over 7,000 women. Thousands of women working in the health care sector have been decorated with governmental awards for their services.

Summary

Extensive enlistment of women in the USSR in social activities as a whole, and in the health care sector in particular, became possible as a result of granting complete social and economic equality to women. This social and economic equality gave women opportunities to develop creative abilities as well as

opportunities to combine their social work and family duties.

The condition that determined an extensive and rapid inclusion of women into the health care sector was the transformation of our country's public health service system on a radically new basis. The creation of the single public health state system, the extension of the wide network of curative-prophylactic establishments (which became centres of highly skilled medical care), all this totally changed the activities of doctors and medical personnel.

Replacing doctor's individual practice in private consulting rooms with collective work performed by a group of specialists, whose work is planned and volume of work is strictly fixed—brought the activities of medical workers into a framework quite acceptable for women.

The effective solution of the medical personnel problem was made possible by the establishment of an extensive network of higher and secondary medical education institutions in the national republics and outlying areas of the country. Universal compulsory education, free tuition at all the educational establishments, the extension of the network of medical education establishments—all these factors provided a massive flow of all categories of medical personnel, including women and representatives of native nationalities into health care services.

The experience gained in our country has convincingly proven the possibility of a sharp increase of health care services in a short historical period. Women's active participation in solving comprehensive problems of protecting people's health was one of the prerequisites of the progress achieved in this field.

In the USSR, experience has proven not only the possibility and expediency, but also the effectiveness of women's activities in medicine. Life itself has proven that in any field of health care and in any medical branch, women can reach the highest professional level and successfully solve any theoretical or practical medical problem.

The survey on the professional orientation of doctors in the USSR showed that there are branches of medicine which women prefer, though there is not a single branch in which women do not major. Over the past decade, the distribution of women doctors among different specialties has stabilized. Considering that one's choice of specialty is determined on the one hand by the specific character and demands of the specialty, and on the other hand by the inclinations and abilities of every doctor, one can conclude that the existing distribution of women doctors in specialties meets both the health care requirements and the interests of specialists themselves, who have chosen the most acceptable field for their professional activities.

The progress achieved by the Soviet health care system, particularly in training medical personnel, poses new and important problems. The key problems are as follows: a further improvement of higher and secondary medical education; elaboration and realization of programs providing a more effective additional training of doctors; more rational utilization of medical workers labour; equipping all categories of medical workers with up-to-date methods of prophylactics, diagnosis and treatment.

The improvement of the quality of prophylactic and curative work depends first and foremost on the technical equipment of the health care establishment and on the perfection of organizational forms which provide optimum conditions for work and creative activities for every specialist. The solution of these problems is the main concern of the entire state system of public health services, in which women play the dominant role.

Approaches to Correct the Underrepresentation of Women In the Health Professions

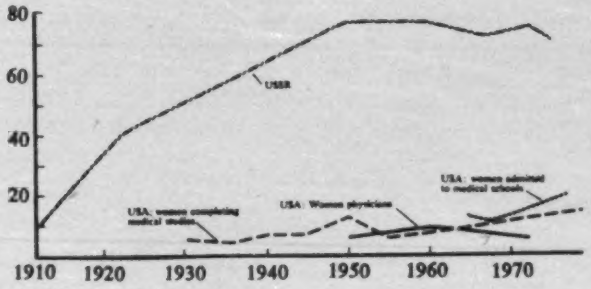
A U.S. Response to a Look at the U.S.S.R.

Mark G. Field, Ph.D.
Professor of Sociology, Boston University; Associate of Russian Research Center, Harvard University; Chairman, Research Committee on the Sociology of Medicine, International Sociological Association, Boston, Massachusetts

It is with a degree of diffidence, if not trepidation that I engage on the thorny path of discussing a paper that touches both on the Soviet health system and on women in health. It is sometimes said there are no experts on the Soviet Union, only varying degrees of ignorance. Perhaps the same might be said, at least in this country, on the involvement of women in health services. A glance at the official program listing the participants indicates, without much doubt, that men are here as much in a minority as they are in the Soviet health service. And yet, the performance of that service in the last half century or so has demonstrated it could operate rather well under those circumstances; perhaps the first lesson that can be learned is: it can be done. It is striking, indeed, to note the degree to which we are all captives of culture-bound stereotypes which often become self-fulfilling prophecies. For the average American, the picture of the typical physician is that of a fatherly looking, white-coated grey-templed gentleman. After a few days in the Soviet Union, which I have visited six times in the last twenty years and where, incidentally I met Dr. Piradova in 1961, the picture is quite different. The "doctor" is a motherly-looking white smocked woman, her hair usually covered by a white round hat. Indeed, when the publisher of my first book "Doctor and Patient in Soviet Russia" submitted to me a choice of pictures on medical subjects from the Soviet Union to grace the book-jacket, I was pleased to find one in which a pleasant woman doctor, holding a stethoscope, is conversing with a bare-chested, robust young man, towering at least half a head above her. In the background, barely visible between the two figures just described, there is another woman, sitting at a desk, reading what looks like a case history. Whether she is a nurse or a physician I am unable, of course, to say. But the conclusion is inevitable: in the Soviet Union, medicine is largely a female domain; in the United States medicine is predominantly a male preserve, and has been ever since statistics have been kept. In the two countries, however, physicians excepted, health personnel tend to be largely feminine.

The magnitude of the difference in the proportion of men and women physicians between the two countries has been charted in Figure 1 which I have compiled from available American and Soviet statistics.[1] It seems evident that at no time in American history has the percentage of practicing women doctors exceeded ten percent, about the same proportion that

Figure 1: Women in Medicine, USA and USSR, 1913-1970 (in percentages of all physicians)



obtained in Tsarist Russia immediately before World War I. It is true that around 1950, the percentage of American women completing their medical studies briefly went over that figure (presumably an echo of the Second World War), but that trend immediately reversed itself, then started to climb again slowly in the mid-fifties (though still remaining below 10 percent). Of late, we have been able to witness a rise in the admission of women medical students (the figure surpassing 10 percent around 1970) and still climbing toward 20 percent. At Harvard Medical School, in the last two years, about one-third of admitted students were women. The Soviet picture is strikingly different, as Dr. Piradova and as Figure I indicates. From 10 percent of all physicians in practice before World War I, the percentage steadily increased until it reached a level of about 76 around 1950, and then peaked and slowly decreased by what looks like a quarter of a percentage point annually. The figure still remains at about 70 percent, or more than seven times the equivalent American figure.

It is my impression that the proportion of three-fourths women in the medical profession was the result of a specific configuration of circumstances in

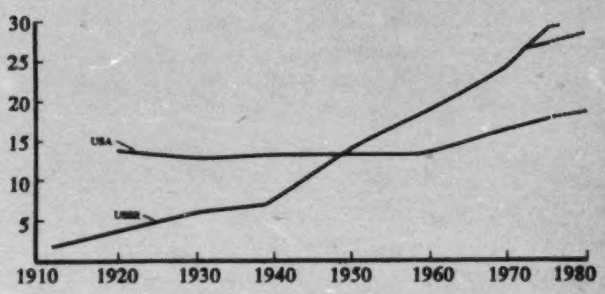
the history of the Soviet Union, and that this percentage will not be maintained in the future. Indeed, as Dr. Piradova informs us, in the 1973-74 academic year only slightly more than half of the Soviet medical students were women (56 percent). This trend was confirmed to me in the course of my most recent visit to the Soviet Union (May-June 1975) and it is quite likely that with such an admission policy, within 20 to 25 years (depending on the attrition rate), we shall see in the Soviet Union a medical contingent about equally divided among the sexes, which might be the way it ought to be after all. On the other hand, it is not unlikely that the percentage of American women in medicine will continue to increase as pressures for equality make themselves felt on admission committees. And thus, in a decade or two, that rather wide gap between the proportion of women in medicine in the United States and the Soviet Union, may well be closed.

I also believe that the most impressive increase in the number of physicians in the Soviet Union in the last half-century or so has been due to the massive influx of women into medicine, particularly in the light of the competing demands for personnel in the technical and military occupations, and the devastating losses both in extraordinary mortality and in birth deficits incurred by the Soviet Union as a result of the First World War, the two revolutions of 1917, the foreign intervention, the civil war, and the massive epidemics of the early twenties; in addition, the dislocations attendant on rapid industrialization and collectivization of agriculture; and the incredibly traumatic impact of the Second World War on the population, and particularly (as in all the previously mentioned events) on the male population.

The excess mortality of the Second World War has been estimated as more than 20 million men (the majority in the productive and reproductive ages), and the birth deficits also at about 20 million. I think thus that, in addition to ideological and cultural factors, there is an important demographic variable (not operative in the USA) that helps to explain the massive entry of women into medicine in the past.

Dr. Piradova mentions a figure of 766,700 doctors for 1973 (of whom 70 percent are women). It should be pointed out that this figure is not strictly comparable to that of physicians in the United States. I assume that Dr. Piradova means what is usually labelled in Soviet tables as "doctors in all specialties, excluding the military". This figure is thus inclusive of physicians, of stomatologists (i.e. doctors with a dental specialization) and dental assistants called in Russian, "dental doctors" *(zubnie vrachi)*, who do not have a higher education. It is thus necessary to discount the number of doctors "in all specialties" by 10 to 13 percent to obtain physician figures that would be comparable to that of the United States. This would then reduce the supply of 30.6 physicians per 10,000 to about 27 physicians per 10,000; a figure which is more than 50 percent higher than the corresponding one in the United States. I have traced the data [2] in Figure 2. It is interesting to note that although the number of physicians in the United States increased 2.5 times from 1910 to 1970, the number of physicians per constant unit of the population remained more or less stable between 1910-1960 (and indeed went down in the twenties).

Figure 2: Medical Density, USA and USSR, (physicians per 10,000 inhabitants), 1910-1970



It is only after 1960 that the availability of physicians relative to the population in the United States began to rise. It should be noted that, to some extent, the increase in the supply of physicians in the United States is due not only to an increase in the number of medical schools and medical graduates (an increase of about 25 percent in the last few years), but also to a large influx of foreign born and trained physicians (FMGs), a minority of whom consists of Americans trained in foreign medical schools. Thus, if we were to compare domestically trained physicians in the two countries, the discrepancy would be even greater. I have pointed out that the increase in the Soviet Union would not have been possible without large number of women entering into medicine. Would it not make sense, in the American context, to replace foreign trained physicians (whether American born or foreign born) by American trained physicians, and emulate the Soviet example by drawing more boldly on women to increase our supply of qualified physicians? One bottleneck in this country, if I read it correctly, is not in the lack of qualified or motivated applicants of both sexes to the medical schools, but in the lack of educational facilities. To remove that bottleneck would necessitate either an increase in the number of medical schools, or an increase in the number of students in each medical school.

To follow Dr. Piradova's figures the 92 medical schools of the Soviet Union turn out about 50,000 graduates annually. This comes to an average of 543 per medical school, a number that most American medical educators would find excessive. But it should be pointed out that included in that figure are the graduates of the different "faculties" in their schools, i.e., of the different tracks of therapy, sanitation and hygiene, pediatrics, stomatology, medico-biological, and pharmaceutical. Thus, the class size in each faculty must be considerably smaller than the figure I mentioned. Incidentally, Dr. Piradova states that every medical institute has all these facilities—which I do not

believe is correct. A medical school may have all of these, but in practice most of them do not.[3] In 1967, only three medical schools had all five faculties; medico-biological was not listed then.[4] But nevertheless, the quantitative progress in the sheer number of physicians has been most impressive.

Indeed, between 1913 and 1970 the magnitude increase in the number of physicians (excluding stomatologists and dental technicians) has been almost 30. Before World War I, the United States had six times as many doctors as Russia; in 1975, the Soviet Union has about twice as many doctors as the United States. In terms of supply per population, or medical density, the Soviets caught up with the Americans around 1950, and left them behind in a typical "scissors" situation. It is possible that the Soviet figure is still an under-enumeration since physicians counted exclude the military whereas the population base includes military. At any rate, this is what permits the Soviet Union to claim the highest "medical density" in the world.

These are, of course, gross figures: they tell us nothing of the distribution of physicians over the territory of each nation, the number of physicians available for primary care, the living and working conditions of physicians and income levels.

On this question of income levels, it may be of interest to note that of twenty-four occupational groups listed in a Soviet statistical handbook for 1973[5] "health, physical culture and social welfare" and "art" were listed as having the lowest average monthly pay of all. At the same time, of all occupational groups listed in the same handbook, the "health physical culture and social welfare" group had the highest percentage of women (85 percent). The income figure (in roubles) was 99.0 as against a national figure for all occupations of 134.9. Thus, the average for all those employed was one-third higher than for those in health, physical culture and social welfare.

Industrial workers (of all types) earned an average of 147.2 or fifty percent more than those in health, etc. Those listed as "engineering-technical workers" earned more than twice. The problem with the "health, etc." figure used here is that it aggregates the data for three different occupations, and that within the health occupations, physicians certainly earn more than the 99 roubles listed. But not much more; probably somewhere around 120 roubles. It might be interesting to see whether an increase in the intake of men into medicine will be accompanied by an increase in the income levels of health personnel, and physicians in particular. I believe there is a move afoot in the direction of a general wage increase for health personnel.

It also seems that both countries face similar problems in moving and keeping doctors in the rural areas (and hence the importance of the feldshers). I would also be interested in knowing a bit more about the representation of women in the medical system. For example, Dr. Piradova mentions Dr. Kovrigina, a former Minister of Health (1959-1964). She is the only woman who, in the course of more than a half century of socialized medicine, occupied the top national position in health. She mentions 12 women as vice-ministers of health for the USSR and union republics. This means a total of 16 ministries (one for the USSR, and one for the 15 republics).

On the assumption that each ministry has at least four or five vice-ministers, the representation of women there is considerably smaller than their proportion in medicine or in health in general. She mentions that 10 percent of the members of the Academy of Medical Sciences are women: if we break this into full members and corresponding members, I believe that the former figure would be closer to 4 or 5 percent than to 10 percent.[6] These are not meant to downgrade the tremendous strides of women in the health services; it is only to suggest that the percentage of women in medicine is not constant throughout the health system.

Dr. Piradova presents an interesting picture of the percentage of women in different specialties (as well as the distribution of specialties among women doctors themselves). I note that 60 percent of all women doctors specialize in therapy (general medicine), pediatrics, obstetrics-gynecology, and stomatology. We also note that among all doctors women constitute over 90 percent of those specializing in pediatrics, but one-fourth of all those in surgery. Dr. Piradova also points to "a progressive tendency towards the extension of specialization, towards the extension of doctors' specialties." I am not sure of the meaning of the word "progressive", whether she meant a "gradual" or a "positive" development. i.e., whether the term was descriptive or normative. I suspect, from the context, that she meant that the increase in specialty practice was normatively desirable, that it was a good development. Let me interject here a note of ambivalence: it seems, at least within the United States context, where specialty practice has proliferated without much planning or forethought, that many are beginning to realize that an increasingly specialized medical profession has its drawbacks in that access to primary care is decreased or phased out, the patient's care is "fractionated", the emotional and phychological needs of the patients tend to be lost in the shuffle, and the integration of increasingly narrow medical outputs into a comprehensive medical product becomes problematic.

I want now to turn to certain structural aspects of health services in the two countries, and to some considerations that may bear on the involvement of women in these services. If we use the basic polarity of economists between a "market" and a "command" economy, and apply it to the health system, we might, at a very generalized level, define the American health system as primarily a "market" health system and the Soviet one as a "command" health system. Historically, medicine (in contrast to elementary and secondary education) has developed in the United States within an entrepreneurial ideology and professional optic in which the physician having invested a great deal of time, effort and money in acquiring a rare good (his knowl-

edge and skill), sets himself up in practice and gets a return on his investment.

It is true that he often offered his services to the community on a sliding scale basis. I think the true meaning of the word "liberal" profession is that the professional is autonomous: he is not part of an organization, neither is he salaried. He gives his services on a fee-for-service basis. A system like this operates largely within the framework of supply and demand, and is quite consistent with a laissez-faire ideology. Historically, this pattern was prevalent in the XIXth century, and in the first half of the XXth. The ideology still lingers on, although objective conditions have made a great deal of it obsolete.

The "command" model, is the one primarily obtaining in the Soviet Union. In that model, the state assumes the responsibility for providing preventive and clinical services to the population as a public service; that service results from planning at all levels of the society, integrated of course with economic planning and development at the national level, and tied to available supplies of financial and personnel resources. The system, furthermore, is funded through general revenues (mostly taxes) rather than on an insurance bases (with actuarially determined risks); and medical facilities are the property of the nation (or administrative divisions thereof), and practically all health personnel become salaried state employees. It is precisely the "organized" nature of the Soviet health system, and the fact that almost all physicians are state employees that permits the regime to control the aggregate bill the society will pay for its health services, and particularly the bill it will pay for personnel.

Under present conditions, such control would be impossible to implement in the United States. Basically, the Soviet health service has become bureaucratized, using the term not in the usually pejorative tone that people reserve for it when faced with the red tape that bureaucracies generate (whether these bureaucracies be public or private), but in the sociological sense used by Max Weber as the most effective and rational way to administer or manage services. One of the characteristics of the involvement of employees in a bureaucracy is the specific nature of their employment, their duties, and their responsibilities.

I was struck that on two occasions, Dr. Piradova came back to the strictly regulated nature of the physician's work in the Soviet Union. "The rights and responsibilities of medical workers are precisely regulated and the volume of work and working hours are strictly fixed." Toward the end of her paper, she comes back to that point by saying, among other things, that the doctors' work is "planned and the volume of which . . . strictly fixed." She also stresses:

> "There is no doubt that the extent to which women in our country were brought into the system of public health services may be attributed to the decisive factor of the utter reorganization of the health care sector on a totally new ground."

Toward the end, she also complements the concept of the planned nature of the doctors work by stating that it be the "replacement of the doctor's individual practice . . . by collective work performed by a group of specialists . . . (which has) brought the activities of medical workers into the framework quite acceptable for women".

I submit that these statements are relevant to an understanding of the nature of medical work today and the involvement of women in it. What Dr. Piradova suggests is that it is precisely the reorganization of health services that makes it possible to involve women on a large scale. Thus, by implication, she contrasts the medical practice of the solo private practitioner as one that is not compatible with other roles women are called upon to perform. By contrast, the ideology of the private practitioner of the type I described above was that his profession was his total life (or almost). He was expected to be available at almost any time of day or night, to be on the breach, so to speak, 24 hours a day . . . seven days a week. That he was, constitutes an important justification for the prestige and the psychic and financial rewards the doctor was able to garner. Although by definition a private practitioner, in fact he often was a public servant. That under contemporary conditions, less and less physicians are willing to work under those conditions is quite clear. If I can read the signals correctly, in the Western world more and more, physicians are beginning to practice in group settings, i.e. in settings that increasingly and for a variety of reasons will conform to the bureaucratic model outlined earlier. That physicians of both sexes increasingly seem to prefer a regulated practice with segmental time responsibilities, with a fairly predictable and steady income, and with definite time off for family, study, recreation and vacation is consistent with trends in industrial societies. It argues that there may be forces in the medical system in the United States that will lead to changes in the direction of a pattern already seen in the USSR.

And I would further argue that, to the degree to which it moves into that "organized" direction, the greater will be its ability to draw women into it. In other words, the more organized a medical system, the less it conforms to the solo private practice "unlimited" model, the more will it be able to provide satisfactory employment to women (and to men also) by making it possible for those in medicine to have a well-rounded life outside of their occupational responsibilities. This incidentally seems to be borne out, for example, in studies conducted in France indicating that women-doctors tend to concentrate into salaried positions and into certain specialties where hours are regular and predictable, rather than in community general practice.

The involvement of women in medicine thus highlights the problems inherent in any society where there is a differentiation between "home" and "job", a situation certainly not common in agricultural and fairly simple societies. The need to "commute" between the two settings in the industrial society, the removal of the worker or professional from his or her home surround-

ings has serious implications for "parenting" functions and indeed, these implications, have traditionally tended to affect women much more than men because of the extension of child-bearing to child-raising functions.

As someone once said "Isn't it marvelous that as soon as a child is born, it finds a mother right here, on the spot, to take care of it". The question of the combination of parenting and work is particularly critical in professions such as medicine. A woman physician who would take ten to fifteen years to raise her children would find herself much more handicapped when returning to her occupation than someone in an unskilled or low-skilled occupation. Hence, the critical importance of making it possible for professionals to be able to be parents *and* professionals at the same time.

Although one might argue that "fathering" is just as important as mothering and that the child be taken care by others (thereby releasing the parents for work in the economy) the whole literature on the psychological consequences of maternal deprivation indicates some important cautions of the degree to which early child-raising can be completely delegated to a group of professional people. (Incidentally, the parental functions mentioned here do not have to be performed by the biological parents).

These are far from trivial questions; they have to do with the manner in which the health system, the family system, the socialization process and the total social system are interdigitated. I am interested in learning that Soviet sociologists are increasingly paying attention to these issues. Thus, we read that the following conclusions regarding professional women were drawn from a special symposium on the "Productive Work of Women and the Family" in Minsk (1969): [7]

1. Women have fewer opportunities for the development of their personalities, for cultural and social activity, for increasing their specialization, or for devoting their time to innovation and invention . . .
2. Women cannot fulfill their function of bringing up their children and controlling their conduct to the degree that they must, which leads to children being left virtually unattended to and lowers the general level of the family's educational endeavor.
3. The physical and psychological fatigue of women creates a negative psychological atmosphere in the family, lowers the "general tone" of family life, causes conflicts and fights between the spouses, reduces the resistance of the family to other pressures, and is one of the major causes of divorce.
4. . . . the contradiction between the vocational and family roles of the women constitutes one of the major factors influencing the lowering of birth rates, above all in the cities and the republics in which women's vocational activity is widespread. . .
5. The above-mentioned contradictions are sometimes resolved by women giving up their vocational pursuits. According to the USSR census, there are more than 10 million women capable of work who do nothing else but take care of children and the household, a large part of whom have vocational training. Thus, there is no return to society on the resources which have been spent on the vocational training of these women . . .

I also think that practically every Soviet time budget study shows quite clearly that compared to men, women have much less leisure time because of their double or triple duties as members of the work force and housewives-mothers. This may also account for the fact that women physicians in the Soviet Union work, on the average, work about 40 percent less time than their male counterparts.[8] Soviet women doctors tend to work a regular number of hours (6.5, 5.5, or 5 per day as the case may be) and then stop working, whereas their male counterparts apparently work an additional half shift. (If this is the case, and if this applies to the two nations, then it stands to reason that the amount of medical acts produced by the two professions must take account of the different sex ratios, one with 70 percent women, the other with 90 percent men).

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Finally, I would like to hear more about certain delicate problems, for example, the handling by women doctors of sexually sensitive areas. I am thinking, for example, of the American stereotypes of what a male physician is entitled to do to female patients, and the problems inherent in the opposite. For example, a report of the Student Task Force of the Joint Committee on the Status of Women at Harvard Medical, Public Health and Dental Schools, entitled "Obstacles to Equal Education at Harvard Resulting from Sex Discrimination" [9] mentions a common complaint of women medical students in that they are not adequately taught how to examine the male genitalia and inguinal region. And the report goes on to state:

> Although male students may receive equally poor teaching they have an advantage—society defines the male doctor as the one who may examine. Should the situation of a female doctor examining a male patient's genitalia be inherently more awkward than that of a male doctor doing a pelvic? [10]

There are undoubtedly many other issues that should be examined and discussed in a conference of this type. A half century of Soviet experiment both with socialized medicine and the utilization of women as doctors should not be ignored any longer. I grant there are many areas in which our two societies are quite dissimilar in the area of medicine and health. On the other hand, I believe that the similarities are fairly large, and are likely to increase as the delivery of health care gets to be increasingly complex under the dual influence of increased demand for services and the increased availability of bio-medical knowledge and technology. These are factors that transcend ideology and politics, and in which a convergence phenomenon can be sighted. Since the Soviet form of medical care delivery resembles, in my opinion, the general form toward which the health systems of industrial nations seem to be evolving, perhaps more can be learned by the Americans from the Soviets than the other way around.

If a generalization can be made, the United States has distinguished itself in the post World War II period

by its achievements in the generation of medical and health-related knowledge. The Soviet Union has distinguished itself by its large scale experiment in the delivery of such knowledge to its population. We can have something to learn from each other, both in lessons of what to adapt, what to adopt, and what to avoid. The employment of women in the Soviet health system is thus one lesson that we ought to study much more carefully than we have up to now.

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Aproaches to Correct the Under-representation of Women in the Health Professions
A U.S. Response to a Look at the USSR

Dentistry as a Career for Women in the United States:
A Discussion with Comparisons to the Soviet Union

Jean E. Campbell, D.D.S.
Practicing Dentist and
Past President of Association of
American Women Dentists
Placentia, California

Dr. Piradova has given us an interesting and informative presentation on the public health care system in the USSR and the role women play in it. The system she has described differs markedly in many ways from health care delivery in this country. My discussion will concentrate on the specific health care field with which I am most familiar, that of dentistry. Not being an authority on dentistry in Russia, my comparisons between the profession in that country and in this country will necessarily be limited.

Dentistry in the United States is a separate and distinct profession rather than a specialty of medicine as it is in Russia and many other countries. The first chartered dental college in the world was the Baltimore College of Dental Surgery, founded in 1840. It was followed by the Ohio College of Dental Surgery in 1845 and the Pennsylvania College of Dental Surgery which opened in 1856. At the present time, there are 58 dental schools in operation with a total enrollment of 20,146 students. Currently, there are about 127,000 licensed dentists in the country. In the 135 years since the establishment of the first dental college, American dentisry has become synonymous with excellence and quality the world over.

Now, let us consider the American dentist. Most of you are probably thinking of a man. This really isn't too surprising since 98 percent of this country's dentists are men. There are many people who have never met a woman dentist, let alone been treated by one. And yet, why should this be—especially when women dentists have been around for a long time.

The first recorded woman dentist in the United States was Lucy Hobbs Taylor. In 1859, after a ten-year career as a teacher, Lucy applied for admission to a medical school in Boston but was turned down because she was a woman. One of the medical professors advised her to take up dentistry as a career instead since it was much more suited to a woman. Taking his advice, Miss Hobbs sought an apprenticeship rather than admission to a dental school.

She applied to nearly all the dentists in Cincinnati, but all declined—many being afraid it would hurt their reputation if it became known they had taken a female apprentice. Finally, she was employed by a dentist who taught her both operative dentistry and basic science. Then in 1861, she applied to the Ohio College of Dental Surgery but was again refused because of her sex. So she did what most dentists of that day did—she opened an office without a license. After several years of practice in Iowa, the State dental society invited her to join its membership. At that time, the society passed a resolution which read in part:

> Resolved, that the profession of dentistry . . . has nothing in its pursuits foreign to the instincts of women, and, on the other hand, presents in almost every applicant for operations, a subject requiring a kind and benevolent consideration of the most refined and womanly nature.

That was quite a statement for 1865!

Lucy was finally accepted by the Ohio College of Dental Surgery, graduating in 1866. In 1867, she married James Taylor whom she taught dentistry. They practiced together in Lawrence, Kansas, until his death in 1886. Lucy continued to practice another 24 years, however, until she passed away in 1910. This remarkable woman had practiced dentistry for nearly 50 years and had forged the way for other women to be accepted by dental schools.

There have been many other outstanding women dentists over the years despite the fact that there were very few women denists at all.

The first textbook on pedodontics, entitled "Operative Dentistry for Children," was authored by Dr. Evangeline Jordan. Dr. Jordan, an 1898 graduate of the University of California Dental School, practiced in Los Angeles from 1899 to 1929. Along with another Los Angeles woman dentist, Dr. Minnie Proctor, Dr. Jordan has been called the "Mother of Pedodontics".

Dr. Gillette Hayden of Ohio and Dr. Grace Rogers Spalding of Michigan were the co-founders of the American Academy of Periodontology. It was their preliminary work that brought together the 18 charter members in 1914. Of these 18 charter members, seven were women! Dr. Spalding later served as President of the Academy and from 1930 to 1949 was the Editor of the Academy's Journal.

In 1917, seven young women studying dentistry at the University of California in San Francisco, decided to form a dental sorority for women since the men students had their fraternities. They called it Upsilon Alpha and within nine years there were eight chapters —in Chicago, Minneapolis, Los Angeles and elsewhere. Over the years, it has continued to grow in membership.

Then in 1921, twelve women dentists decided to establish an association—an organization by which they could come together for friendship at the annual meetings of the American Dental Association, a time when they had felt lonely and out of place by themselves. Thus, the Association of American Women Dentists came in to being during the A.D.A. meeting in Milwaukee. The first President was the distinguished
34 pedodontist from California, Dr. Evangeline Jordan. The time was obviously ripe for such an organization—two years later when it met in Cleveland, the 12 had grown to over 200 members. In 1924, Dr. Gillette Hayden served as President and in 1927, Dr. Grace Spalding held the office. Over the years, the Association of American Women Dentists has been active in promoting dentistry as a career for women.

In 1929, the well loved and distinguished Dr. Hayden died an untimely death due to cancer. Dr. Hayden had been a professional woman of the highest order as well as a skillful clinician and humanitarian. She was the great-granddaughter of Dr. Horace Hayden, the co-founder of the Baltimore College of Dental Surgery, but she left her own mark on dental history. At their 1930 meeting, the Association of American Women Dentists wished to honor the memory of this great member. Thus, it was that the Gillette Hayden Scholarship Loan Fund was started. Dependent on voluntary contributions, it grew slowly, particularly during the Depression years. But as soon as possible, the fund began making low interest loans to junior, senior, and graduate women dental students. Today the fund is known as the Gillette Hayden Memorial Foundation and is receiving more and more requests for loans as the number of women dental students increases.

Although the American College of Dentists had been in existence for many years, it was not until 1950 that Dr. Ruth Martin became the first woman to be made a Fellow of the College. She was a 1923 graduate of Washington University in St. Louis and a charter member of the American Board of Pedodontics.

And it was in the 1950's that Dr. Nancy Holmes, a periodontist from Dallas, became the first woman in the U.S. and the second in the world to be made a Fellow of the International College of Dentists.

Now that you've heard the accomplishments of some women dentists over the years, let's take a closer look at dentistry as a career choice for a woman.

U.S. dentistry has always had a low representation of women, even compared to the professions of medicine, law, and pharmacy. Currently, just under 2 percent of our dentists are women. This a drop from the 1920 figure of 3 percent. While the percent of women dentists has remained quite stable for the past ten years, the percent of women physicians has risen from 5 percent to around 10 percent. One wonders why this should be when medicine is as long and as difficult a course and doesn't offer women some of the career advantages that dentistry does.

Dr. Piradova has told us that in the USSR, women comprise 70-80 percent of the stomatologists. Stomatology is the specialty of medicine that covers the field we know as dentistry. Is Russia unique in having such a predominant number of women dentists? The answer is no. In France, 25 percent of the dentists are women. South American countries average about 50 percent women practitioners. In Norway, Poland and Finland, 75-80 percent of the dentists are women. Certainly the large percentages of women dentists in so many countries would seem to indicate that dentistry is a field that is congenial to women.

Next, let us examine the question, "What is there about dentistry to attract a woman?" First, she can set her own hours. Night calls and emergencies are usually infrequent. This allows her to combine her career with marriage and a family if she wishes. In Russia, the doctors' hours are rigidly fixed, apparently allowing little leeway in scheduling one's working time. The working Russian mother is provided with a network of free child care centers. The American mother with a dental practice has nursery schools available, at a cost, for her younger children and is free to schedule her working hours to coincide with the school hours of her older children. Some women dentists in this country employ full time housekeepers and others have located their offices in their homes. Their income as dentists does give them the financial resources to pay for these expenses.

Secondly, it gives her prestige in her community. In addition, she can expect a good income, and the odds today are that a wife and mother will spend 25 years or more working outside of the home. Dr. Piradova's paper did not indicate the prestige level of the profession in Russia nor did she cover the salary or income potential.

A fourth attraction of dentistry is one common to both the U.S. and USSR—that is the feeling of providing a humanitarian service.

And finally, dentistry offers a woman several choices of practice. She can choose private practice, either in general dentistry or a specialty; and 31 percent of women dentists do limit their practices to one of the eight specialties compared to 10 percent of men dentists. By far, the largest percentage of all U.S. dentists, male or female, are in private practice. This may be in the form of a solo practice, a partnership, or a group practice of three or more dentists. This is probably the most striking, basic difference between dentistry in the USSR and in this country. One of the reasons American dentists frequently give for having chosen dentistry as their career was their desire for independence, that is, being their own boss. A second

choice is to work in a government hospital, either with the Veterans Administration, Public Health Service, or a branch of the military. This offers her certain advantages not found in a private practice. Here she can cooperate with the physician in providing total health care to the patient.

A hospital can also provide many facilities and services not found in a private office. However, very few women seem to choose this form of practice. A third area open to a woman dentist is the field of dental research. This can be done in conjunction with either a dental school, hospital, or commercial firm. There are the fields of dental materials, oral cancer, periodontal disease, and many more covering every dental specialty. Or she may choose to go into dental education. Here she can either work with the dental students in the classroom or on the clinic floor. In addition, a dental school offers administrative positions.

Now let us consider for a moment the special qualities that women offer to dentistry. Women's inherent gentleness, patience, and sympathy are certainly attributes ideally suited to dentistry. These are the same qualities that make women such excellent nurses. They are also most useful in combating the fear and apprehension with which many patients face a dental appointment. Most women have a natural aptitude for treating children, and young children are usually much more at ease with a new unfamiliar woman than a man. Patients seem to appreciate the woman dentist's smaller hands. Other attributes would include an artistic sense, attention to small details, and the ability to do fine, delicate work with her hands.

I am often asked why more young women don't go into dentistry since it holds so many obvious advantages for them. One of the main reasons is that they never even think of it as a career choice. In this country, dentistry is thought of as a man's profession, just as in Russia it appears to be a woman's. Girls need to be told about dentistry at the high school or even junior high school level. Too many are in college before they consider it and would then need to take many additional courses to satisfy pre-dental requirements. Another reason is the idea that dentistry is too strenuous for a woman. With the equipment and techniques available to U.S. dentists today, no unusual amounts of strength or stamina are required. Finances play a large part in the career decision as a dental education is one of the most expensive. Many parents feel that they should put their sons first—that their education is more important than a daughter's. Dr. Piradova has mentioned the tuition-free education available in the USSR as one of the factors in solving her country's medical personnel problem. It would also have removed this barrier to women entering the profession.

A fourth reason for not choosing dentistry as a career is the opposition and discouragement many young women receive from parents, friends, or teachers. Another factor is that a dental education is a relatively long and difficult one. The majority of the students graduating from dental schools today have had seven to eight years of college. Specialty training, if desired, will take another two to three years. I believe that in Russia it takes five years of college to obtain a Bachelor of Medicine degree in stomatology. The majority of the stomatologists hold this degree while a smaller percent eventually earn the advanced Doctor of Medical Science degree. The U.S. dentist graduates with the full Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.D.M.) degree. Nevertheless, our dental profession has always encouraged its members to continue their education. In fact, the American Dental Association Principles of Ethics states that "Every dentist has the obligation of keeping his knowledge and skill freshened through all his professional life." In recent years, some States have formalized this by setting a specific number of hours of continuing education as a requirement for relicensure. 35

And finally, there is the dichotomy about marriage. Women are often told that if they choose a masculine profession like dentistry, they probably won't find a husband. On the other hand, women have been turned down by dental schools on the basis that they will probably marry after graduation and never practice, thus taking the place of a man in school who would have practiced for many years. So, you're damned if you do and damned if you don't! Actually, both statements are fallacies. The marriage rate for women dentists is about the same as for all college educated women. 85 to 90 percent of all women dentists under the age of 65, married or single, are in active practice even after children are born. In fact, I'm constantly amazed at the number of women dentists in their 70's, 80's, and even 90's who are still practicing. During the years I spent as an officer in the Association of American Women Dentists, I had an opportunity to meet and/or correspond with many women dentists throughout the country.

There's 94 year old Dr. Mable Dixon in Nebraska who finally retired seven years ago after 63 years of active practice. She was honored by her State dental association as its longest practicing member when she retired.

In North Carolina, there is the amazing Dr. Daisy McGuire, matriarch of a dental dynasty. She has three daughters, all of whom are dentists as well as a sister, niece, husband, and two sons-in-law! The daughter of a dentist, Dr. McGuire began her dental career with a year's apprenticeship in 1899. For the next six years, she traveled through North Carolina by horse and buggy and on horseback, practicing dentistry. In 1905, she enrolled in dental school. Since graduating in 1908, she has practiced in the same office for 67 years! At the age of 95, she is her State's oldest practicing dentist. Three years ago, she wrote to me saying she was still making dentures and hoped to continue doing so for a few more years. How many dentists can match her record?

Then there was the rather frail looking, 78-year-old woman dentist I met at the 1967 A.D.A. meeting here in Washington, D.C. She told us that when she

had reached the age of 73, she had finally hired a dental assistant. She starts practicing at 7:30 a.m. and quits about 6:00 p.m. By the time she was 70, she found she was getting tired about 4:30 in the afternoon. She had found the assistant, who comes in at 8:30 a.m. and leaves at 5:30 p.m., to be a big help!

I could go on with many more such examples, but I think I've made my point that women dentists don't waste their education.

I think perhaps it's not so surprising that there are very few women dentists but, rather, there are any at all with the number of handicaps that have existed. The majority of women who have entered dentistry have done so despite numerous discouragements.

The next question to be considered is "How can we attract qualified women to dentistry?" First, we must
36 make high school and college counselors more aware of dentistry as a profession for women. Few girls ever have dentistry suggested to them as a possible future career choice. The earlier in their education they begin thinking about dentistry, the easier it is for them to prepare for it by taking the necessary courses. In recent years, several dental schools across the country have begun active campaigns to recruit more women students to their schools.

One of the recruitment efforts with which I am most familiar is UCLA's program, initiated by Dr. Frida Xhonga. In her native Latvia, many of the dentists were women and she was surprised by the difference here. Dr. Xhonga has held luncheons at UCLA Dental School for 15 to 20 high school counselors at a time. After some informal conversation and lunch, she shows them her slide series on the life of a woman dental student. Then the Dean of Admissions explains entrance requirements and dental school curriculum. This is followed by a question and answer period and a tour of the dental school.

I participated in one of these luncheons and saw first hand what a remarkable change occurred in the counselors' attitudes during the program. Most of them admitted that they had never suggested dentistry as a career to a girl student. After hearing the facts, most of the counselors were openly enthused about the potential dentistry holds for women. These programs seem to be having very positive results at UCLA. In 1971, they accepted seven women in their freshman class of about 100; in 1972, they accepted 17 women; and in 1973, they took a record 33! In past years, very few women have been accepted by dental schools but then again, not very many even applied for admission. In 1973, UCLA had over 100 women applicants. I'm sure that the impetus at many schools for recruiting more women students can be attributed, in part, to the federally funded minority programs.

Secondly, the dental profession at all levels should help educate the public and parents to the fact that dentistry needs women. This could help remove the resistance some young women encounter from their parents and friends when they consider dentistry as a vocation.

Some years ago, I was stressing a third area of need. This was the need to have career guidance materials available on dentistry as a career for women. Then, in 1968, the Association of American Women Dentists, in cooperation with the A.D.A., published a career brochure that is geared toward the advantages that denistry offers to women in particular. These pamphlets have been distributed as widely as possible throughout the United States. In 1974, the pamphlet was revised and updated. It is available upon request from the A.D.A. I feel that this brochure focused the attention of many women on dentistry as a career choice—women who would never have thought of dentistry otherwise. In 1973, a color film entitled "Where I Want To Be—The Story of a Woman Dentist" was completed by HEW's Division of Dental Health in San Francisco. This 28 minute movie makes an excellent adjunct ot any talk on dentistry as a career for women. For the past few years, the A.D.A. has devoted one page in its career guidance pamphlet to women and dentistry.

Finally, women dentists should talk to groups of high school and college girls, pointing out, from first hand experience, the advantages of a dental career and emphasizing that the profession and homemaking are compatible.

These various recruitment programs are definitely showing results. For years, the percentage of women dental students in this country remained at 0.75 percent. But in 1971, the percent of women students doubled; in 1972, it doubled again to 3.4 percent; and in 1973, the A.D.A. reported a 53 percent increase in women enrolled in dental schools. The 1974-75 report is even more encouraging. There are currently 1,361 women enrolled in dental schools or 6.8 percent of all the students. As these women graduate, we should see a corresponding increase in the percentage of U.S. women dentists.

How are women dentists accepted by their male colleagues? I would say that by large, they have been well accepted. Naturally, there are some men who are very opposed to women entering their field and others who are all for it. The remainder don't seem to express feelings either way. Of course, there have been so few of us in the past that perhaps the men didn't feel too threatened! At a time when there is a great deal of talk about unequal pay for a woman doing the same job as a man, it is interesting to note that a woman in a private dental practice will not encounter this problem. She is free to set her own fees and build her own practice. Do women dentists have trouble establishing a busy practice? There is evidence to the contrary—most women who have been practicing for several years indicate that they have a satisfactory practice. While there will probably always be a segment of the public who would not choose to go to a woman dentist, there seems to be a growing number who are specifically looking for one. Of course, in today's economy, recent graduates, male or female, are finding it difficult to establish themselves.

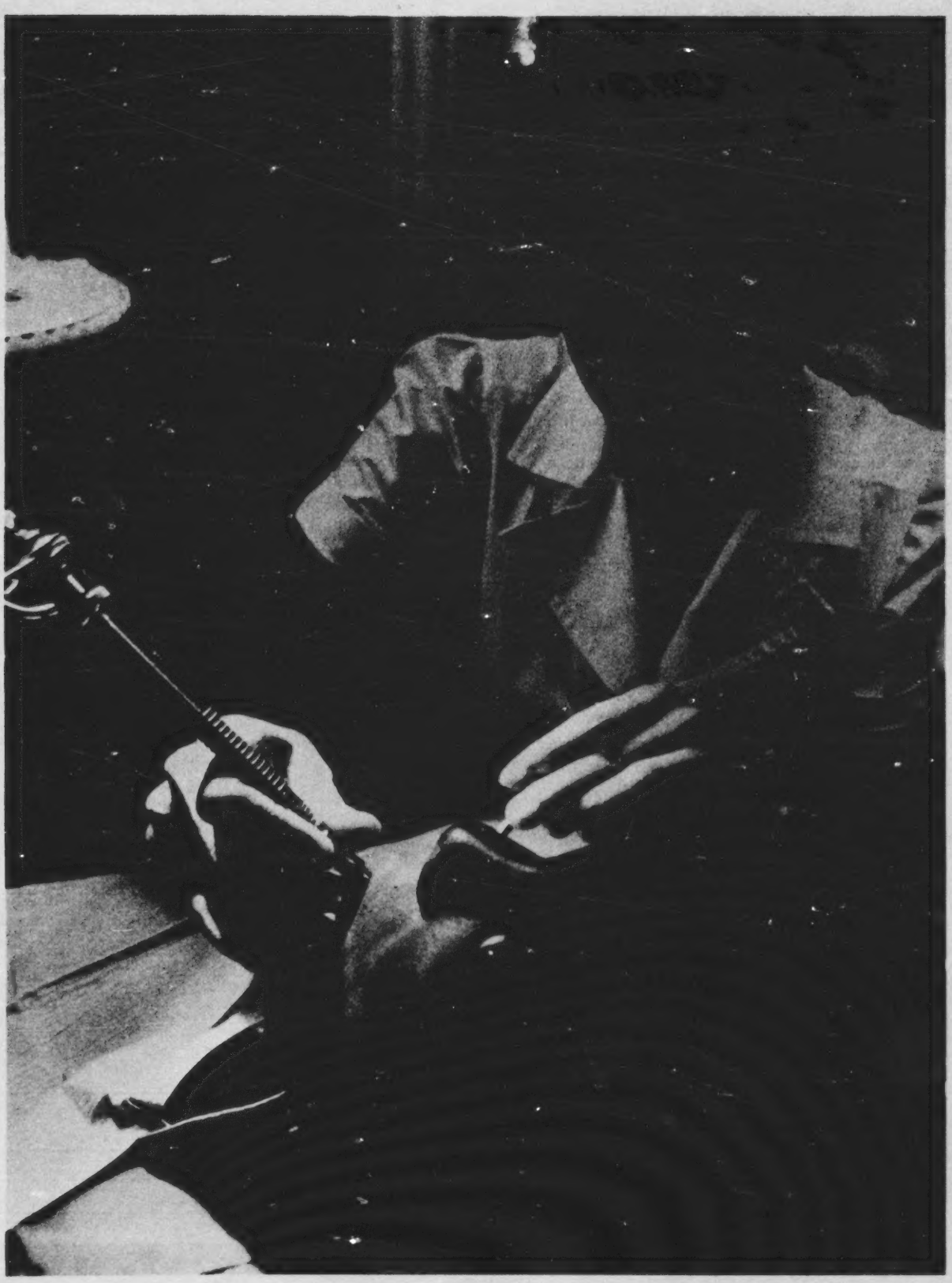
Up until recently, women graduating from dental school sometimes found it much more difficult to secure a loan to open their office than did their male classmates. Bank policies have undergone changes, however, due to recent legislation which have eliminated this problem. The picture is a little different for women dentists involved in full time teaching in a dental school. Many seem to find that promotions and salaries do not increase equally with those of their male colleagues. There are very few women who are full professors. While there are a few women assistant or associate deans, no U.S. dentalschool is, or has been, headed by a woman. I understand, however, that this situation exists throughout the academic community and is not unique to dental education.

Before concluding this discussion, there is one more factor to be considered. Can the underrepresentation of women in U.S. dentistry be corrected by the application of any of the measures used in the USSR? Dr. Piradova has stated that the decisive factor in bringing women into the health field in Russia was the total reorganizaion of medical care into a single state health system. As a corollary, medical care was shifted from individual offices to a network of out-hospital health care establishments. In addition, the volume of work, the rights, working hours, responsibilities, and wages of the medical workers were strictly fixed.

In the past five years, the number of women enrolled in American dental schools has increased 900 percent. It is apparent that great strides have already been made in correcting the underrepresentation of women in this profession. The small percentage of women dentists in this country has never been due to the profession of dentistry being unattractive to women. Instead, it can be attributed to the factors I discussed earlier.

Therefore, in order to attract more women to dentistry, it is necessary to remove those factors by presenting the true facts about a dental career rather than by changing the method of dental practice in the country. It is really the private enterprise system of American dentistry that makes the profession so attractive to women. In a private practice, there are no fixed hours, you are your own boss, the income is good, and the type and place of practice is up to you. One can't help wondering whether the total reorganization of medical care in the USSR was as decisive in bringing women into the field as it was in driving men out of it. It is not uncommon for women to fill the void created when an occupation is no longer attractive to the men who used to fill it. 37

In conclusion, the efforts that have finally culminated in the marked rise of women enrolled in U.S. dental schools in the past five years must be continued and, if possible, expanded. We've only just begun to draw upon this nearly uptapped resource!



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Aproaches to Correct the Underrepresentation of Women in the Health Professions: The Scandinavian Experience

Sex Roles Among Physicians and Dentists in Scandinavia

Elina Haavio-Mannila, Ph.D.
Professor of Sociology
University of Helsinki
Helsinki, Finland

In all societies there has always existed some kind of division of labour between sexes. There are very few occupations in which men and women are as evenly represented as they are in the total population. All over the world there are some general features in this division of tasks. Occupations which demand taking care of other people, like nursing and social work, are feminine in most societies. Professions giving high material rewards and social status are usually masculine. But the division of labour between the sexes is not universal: It varies in different times and societies.

The high status health professions like those of physician and dentist are interesting examples of this variation. Emphasis on the nurturing aspects of these professions, combined with an official ideology favouring equality of the sexes, has made them feminine in the socialist countries. The high social status attached to the healing power of these professions has kept them as predominantly masculine occupations in many capitalist countries like the United States of America.

The Scandinavian countries are in an intermediate position. But even among them there is considerable variation which is linked to differences in the status of men and women in these societies, and probably not so much to differences in the medical systems which are fairly similar.

In this paper, sex roles among physicians and dentists are studied in four Scandinavian countries: Denmark, Finland, Norway and Sweden. Data on sex roles in medical education and in the type of economical activity, work load, and economical rewards of physicians and dentists will be presented as much as

Table 1: Number and Proportion of Women Among Physicians in Scandinavia, by Country: 1945-1975

Year	Norway	Sweden	Denmark		Finland
			Private Practice	Hospitals	
	Number of women				
1945	211	....	....	....	234
1950	340	442	240	293	427
1955	....	642	....	....	524
1960	426	993	285	485	641
1965	....	1,304	1,032*		886
1970	643	1,887	1,345*		1,339
1972-75 [1]	824	2,429	2,258*		1,801
	Percent				
1945	8.0	....	....	....	15.0
1950	10.0	9.0	10.0	15.0	21.0
1955	....	11.0	....	....	22.0
1960	10.0	14.0	11.0	18.0	22.0
1965	....	15.0	16.0*		24.0
1970	12.0	17.0	18.0*		27.0
1972-75 [1]	13.0	19.0	25.0*		28.0

* Private practice and hospitals combined
[1] Norway 1973, Sweden 1972, Denmark 1975, Finland 1972
Source: Official Statistics (See Bibliography)

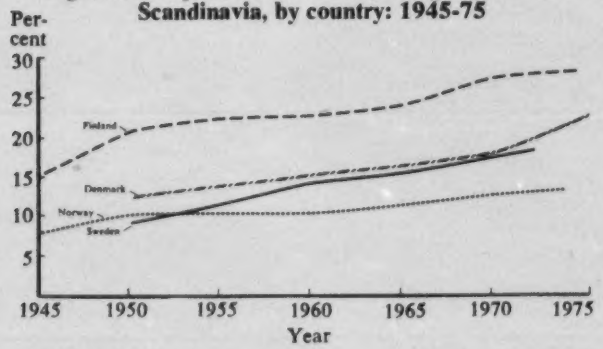
possible. At the end of the paper, descriptions of these medical professions will be tied to other data on sex roles in Scandinavia in order to find some explanation for the variation between the countries.

Sex role differentiation in medicine and dentistry is measured by calculating the proportion of women instead of men: this is due to the under representation of women in these high status occupations.

Trends in the Proportion of Women Among Physicians and Dentists

In all Scandinavian countries, the proportion of women in medicine has been increasing since 1945 (Figure 1 and Table 1). The growth rate has been slowest in Norway, which has remained "behind" Denmark and Sweden, though in 1950 all three were at the same level. Finland has always been far "ahead" of the other Scandinavian countries. In 1970, the percentage of women among physicians was 27 in Finland, 18 in Denmark, 17 in Sweden, and 12 in Norway.

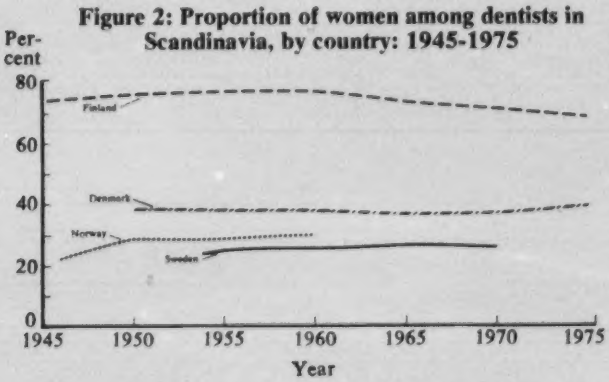
Figure 1: Proportion of women among Physicians in Scandinavia, by country: 1945-75



The proportion of women among dentists is higher than among physicians in all the Scandinavian countries: in 1970 it was 72 percent in Finland, almost 40 in Denmark and about 30 in Sweden and Norway. No upward trend in the proportion of women can be seen since the Second World War. (Figure 2 and Table 2)

The predominantly feminine character of dentistry in Finland is an exception to the dominance of men in these high status health professions. In 1939, dentistry was already 73 percent female. Unfortunately, I am not able to explain how and why dentistry so early became socially defined as a feminine profession. It still has a high status and also a high income level; characteristics not common in feminine occupations. In the professional association of Finnish dentists however, men dominate. Only one to three women have since the war been members of the board which has eight to eleven members and one to five women have participated in the work of the council of nine to twenty-four delegates. The professional association has been able to keep the dental fees high, perhaps because of its male domination. However, from the point of view of democratic and proportional representation of members in the decisionmaking bodies of the association, the situation is unfair. In the Finnish Medical Association men also dominate but it is more understandable because only a quarter of medical doctors are women, compared with three-quarters in dentistry.

Figure 2: Proportion of women among dentists in Scandinavia, by country: 1945-1975



The proportion of women in the medical profession will probably continue to increase in the future. The percentage of women among medical students in the four Scandinavian countries is higher than among all physicians (Table 3). In Denmark and Sweden the proportion of female dentists also will be increasing. But that will not be the case in Norway and Finland where the percentage of women among students of odontology is lower than in the whole profession.

Compared with academic fields on the average, the proportion of females in medicine is quite low. (Table 3) In Norway and Sweden the sex division among students of odontology is similar to that among all university students. In Denmark and Finland there are more women students in the departments of odontology than in the whole university.

The high status of the medical faculty can be seen in the large proportion of medical students with the highest degree, *laudatur*, in the Finnish matriculation examination. (Figure 3, Table 4) Since 1959, female students at the University of Helsinki have in general passed their matriculation examination with better grades than male students. This applied especially to the medical students between 1958 and 1971. Since 1945, in order to enter into the medical faculty, special points could be earned by military service. They were available only for men. Women had to have better school grades to get entrance to the faculty. In addition to school grades and "military points," a special entrance examination was used when selecting new students. The present selection system is based on school grades, with an emphasis on natural sciences, and entrance examination only. Its effect can be seen in the almost equal school grades of new male and female medical students since 1972, when the military points had been abandoned. This change in the selection procedure has also drastically increased the proportion of women among the new medical students in

Table 2: Number and Proportion of Women Among Dentists in Scandinavia, by Country: 1945-74

Year	Norway	Sweden	Denmark		Finland
			Independent	Employees	
	Number of women				
1945	310[1]	....	....	....	805
1950	388[2]	....	375	322	1,014
1954	....	975	....	....	1,176
1960	751	1,426	370	555	1,411
1965	....	1,723	1,054*		1,658
1970	....	1,971	1,264*		1,984
1974	....	....	1,517*		2,274
	Percent				
1945	21.0[1]	....	....	....	75.0
1950	23.0[2]	....	29.0	67.0	77.0
1954	....	25.0	....	....	77.0
1960	30.0	26.0	25.0	62.0	77.0
1965	....	27.0	37.0*		74.0
1970	....	27.0	38.0*		72.0
1974	....	....	41.0*		70.0

*Independent and employees combined

[1] 1946

[2] 1949

Source: Official Statistics (see Bibliography)

Table 3: Number and Percent of Women Among Students of Medicine, Odontology and All Students in Scandinavia, by Country: 1966-73

County	Year	Students of medicine		Students of odontology		All students	
		Number	Percent	Number	Percent	Number	Percent
Norway							
	1966	165	16.0	116	26.0	5,040	24.0
	1967	207	18.0	127	25.0	5,342	24.0
	1968	219	18.0	125	23.0	6,029	25.0
	1969	261	18.0	146	24.0	9,420	27.0
	1970	276	17.0	165	24.0	8,446	28.0
	1971	324	18.0	170	25.0	9,858	30.0
Sweden							
	1966	1,212	24.0	474	37.0	27,935	37.0
	1967	1,351	25.0	541	38.0	34,010	38.0
	1968	1,644	26.0	607	39.0	38,190	38.0
	1969	1,709	26.0	659	39.0	48,320	38.0
	1970	2,007	27.0	663	37.0	45,790	38.0
	1971	2,056	27.0	675	36.0	43,105	37.0
	1972	2,231	24.0	647	35.0	42,180	37.0
	1973	2,110	29.0	697	37.0	40,953	38.0
Denmark							
	1966	1,431	25.0	515	43.0	17,825	36.0
	1967	1,577	25.0	582	46.0	19,141	36.0
	1968	1,569	24.0	597	47.0	20,953	36.0
	1969	1,611	24.0	620	48.0	24,993	36.0
	1970	1,785	26.0	611	49.0	24,402	34.0
	1971	1,936	27.0	605	49.0	26,753	36.0
Finland							
	1967 (Spring)	631	31.0	408	64.0	22,001	49.0
	1968 (Spring	698	32.0	404	62.0	....	....
	1968 (Autumn)	635	30.0	403	61.0	25,855	48.0
	1969 (Autumn)	660	30.0	412	60.0	27,504	48.0
	1970 (Autumn)	691	31.0	411	58.0	28,176	48.0

Sources: Official Statistics of Norway, Universities and Equivalent Institutions, Educational Statistics.
Statistical Abstracts of Sweden.
Statistical Yearbook of Denmark and Statistical Yearbook of UNESCO.
Official Statistics of Finland XXXVII, Higher Education.

Helsinki: in 1971-72 it was 22 percent*; in 1972-73 it was already 49 percent, and in 1973-74 more than half (51 percent). Before the reform, the very low proportion of new women students at the faculty of medicine in Helsinki (the largest in Finland) would have decreased women's proportion in the medical profession in Finland. The percentage of women in the medical faculty of the University of Helsinki had been slowly declining since 1957 as one can see from Table 5. It was really time to abolish the discriminatory military points.

Figure 3: Proportion of students with highest degree (laudatur) in matriculation exam at University of Helsinki, Finland, by sex and faculty: 1948-1974

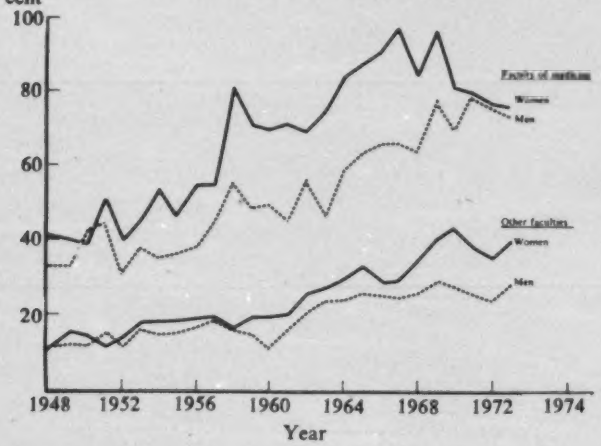
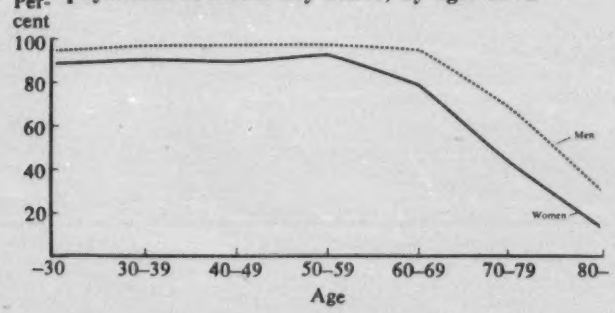


Figure 4: Proportion of male & female Norwegian physicians economically active, by age: 1972



It is interesting to examine the effects of the selection system from the sex roles point of view in the other Scandinavian countries, too. In Denmark, "according to Danish law the university is open to everybody who has passed the final examination of the "gymnasium", and the student is free to choose what faculty he wants to enter. Consequently, there is no possibility for selecting students or limiting the number of students who want to enter medical school. . . . Many students leave medical school within the first year or two, even before appearing for any formal examination. Some fail to pass an early examination in chemistry, or later a rather strict examination in anatomy, physiology and bio-chemistry. Only 65 percent of the male students and 40 percent of the female students complete the pre-clinical years of the curriculum. After this selection, very few fail to go through the clinical years of the curriculum and the final examination." [1] In this "self-selection" process women seem to drop out of the medical school to a greater extent than men.

In Sweden, medical students are selected on the basis of their secondary school achievements only. Entrance is limited to those who have taken many courses in natural sciences and mathematics at the secondary school and have achieved fairly good grades. At school, boys have concentrated on these fields more than girls. This may be one reason for the low proportion of women at medical school.

Sex Difference in Further Education

Positions of higher status in society are usually occupied by men. This rule applies to the low percentage of women among medical doctors who have published a doctoral dissertation. From 1945-46 to 1972-73, the proportion of women among new medical doctors in Finland has varied between 0 and 29 percent. (Table 6) It was higher in 1948-54 than in the late 1950's and in the early 1960's. At the end of the 1960's the proportion of women's doctoral dissertations began to increase again. The last available data from 1972 show that 20 percent of the new medical doctors in Finland are women. This percentage is quite high when one compares it with that in the other faculties. According to a survey by Aino Tuohinto (1966) only in the humanities are there more women presenting doctoral dissertations than in medicine.[2]

Another step upward on the professional ladder is specialization. In Finland, women specialize almost as much as men. While 28 percent of all physicians in 1974 were women, 25 percent of the specialists were. In Norway, in 1972 the corresponding percentages were thirteen and nine; the difference was somewhat larger than in Finland. The special fields selected by women physicians are to a large extent, traditionally feminine. In Finland in 1973, as many as 22 percent of the female but only five percent of the male specialists had chosen pediatrics or child psychiatry as their special field. The proportions of women in dermatology, veneral diseases, pulmonary diseases, tuberculosis, and in opthalmology were quite high too. (Table 7) Males were heavily "overrepresented" in surgery, ear, nose and throat disease, and internal medicine. The high proportion of women in child psychiatry in Finland, according to an American psychiatrist, led to a situation where the whole field of child mental health care has a very low status and income level.

Sex Differences in Economical Activity and Type of Work

The economical activity rates of both male and

* In the two other medical schools in Turku and Oulu the proportion of women students was higher—they did not give "military points" to the male applicants.

Table 4: Number and Proportion of Men and Women Students with the Highest Degree (laudatur) in the Matriculation Examination Among the New Male and Female Students at the Faculty of Medicine and Other Faculties at the University of Helsinki, Finland: 1948-1974

	Faculty of Medicine				Other faculties			
	Men		Women		Men		Women	
Year	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1948–49	22	33.0	19	41.0	88	10.0	73	10.0
1949–50	28	33.0	19	40.0	75	11.0	118	15.0
1950–51	39	43.0	14	38.0	93	12.0	126	14.0
1951–52	37	45.0	16	52.0	112	15.0	122	12.0
1952–53	29	32.0	12	41.0	91	12.0	129	13.0
1953–54	40	38.0	24	46.0	128	17.0	183	18.0
1954–55	25	36.0	26	54.0	136	14.0	204	18.0
1955–56	26	37.0	17	47.0	134	15.0	247	18.0
1956–57	24	38.0	18	55.0	149	17.0	242	19.0
1957–58	35	46.0	20	54.0	173	20.0	256	18.0
1958–59	40	56.0	30	81.0	165	15.0	231	15.0
1959–60	41	49.0	15	71.0	150	14.0	250	19.0
1960–61	47	50.0	21	70.0	150	12.0	299	19.0
1961–62	49	45.0	41	71.0	226	17.0	365	20.0
1962–63	56	57.0	52	69.0	265	21.0	464	26.0
1963–64	50	47.0	43	74.0	325	23.0	575	27.0
1964–65	74	59.0	46	84.0	398	23.0	622	30.0
1965–66	91	64.0	35	88.0	485	26.0	767	33.0
1966–67	76	67.0	35	92.0	450	25.0	726	29.0
1967–68	83	67.0	38	97.0	432	24.0	672	29.0
1968–69	82	64.0	42	86.0	449	26.0	710	34.0
1969–70	101	78.0	32	97.0	463	30.0	726	41.0
1970–71	90	71.0	27	82.0	384	28.0	569	43.0
1971–72	91	79.0	33	80.0	379	26.0	511	38.0
1972–73	87	76.0	84	77.0	340	24.0	509	36.0
1973–74	73	73.0	79	77.0	339	28.0	627	40.0

Source: Helsingin yliopiston luettelo 1974–75.

female physicians and dentists are very high in Scandinavia. (Table 9) In Finland, there is no sex difference among physicians; more than 90 percent of both men and women are economically active. In Norway four percent of the male but thirteen percent of female physicians are not active in their occupation. The lower economical activity rate of women is apparent in all age groups in Norway. (Figure 5, Table 10)

Among dentists a sex difference in economical activity can be seen even in Finland. Ten percent of the women but only four percent of the men are not economically active.

Sex differences in economic activity are thus larger in a country which has only few women in medicine and dentistry than in a country which has more women in these professions. Sex roles are more traditional in dentistry than in medicine: in Finland more women dentists than women physicians stay outside the labour force. Dentistry is a more feminine field than medicine. Sex role traditions in a country and in a profession seem, to a certain extent, to determine the economic activity rates of female professionals.

It is not easy to get a clear picture of the proportion of men and women in the different occupational positions of medical work. The data presented in Table 11 are scattered and not easily comparable.

Table 5: Women in the Faculty of Medicine at the University of Helsinki: 1947-1974

Year	Percent	Number
1947	42.0	378
1948	42.0	412
1949	40.0	407
1950	39.0	425
1951	39.0	420
1952	40.0	435
1953	38.0	426
1954	39.0	441
1955	40.0	442
1956	40.0	426
1957	40.0	430
1958	39.0	430
1959	38.0	435
1960	37.0	439
1961	35.0	422
1962	36.0	448
1963	37.0	479
1964	37.0	503
1965	36.0	508
1966	35.0	501
1967	36.0	523
1968	36.0	563
1969	34.0	544
1970	32.0	508
1971	31.0	469
1972	31.0	483
1973	35.0	547
1974	38.0	590

Source: Helsingin Yliopiston luettelo lukuvuonna 1974-75.

Table 6: Number and Proportion of Women Among Persons Presenting Doctoral Dissertations in Medicine in Finland 1938-73

Year	*Percent*	*No.*	*Year*	*Percent*	*No.*
1938–39	12.0	2			
1945–46	—	—	1960–61	7.0	3
1946–47	—	—	1961–62	9.0	3
1947–48	9.0	2	1962–63	11.0	3
1948–49	20.0	5	1963–64	10.0	3
1949–50	3.0	1	1964–65	2.0	1
1950–51	13.0	3	1965–66	10.0	6
1951–52	13.0	2	1966–67	2.0	1
1952–53	17.0	4	1967–68	6.0	4
1953–54	11.0	3	1968–69	14.0	7
1954–55	29.0	7	1969–70	15.0	10
1955–56	6.0	2	1970–71	13.0	7
1956–57	9.0	3	1971–72	10.0	8
1957–58	3.0	1	1972–73	20.0	17
1958–59	3.0	1			
1959–60	4.0	1			

Sources: Official Statistics of Finland XXXVII:1, Higher Education and Statistical Yearbook of Finland.

Table 7: Number and Proportion of Women Among Specialized Physicians in Finland in 1973, by Field of Specialization

Field of Specialization	Percent	Number
Total	23.9	659
Surgery	2.3	10
Internal diseases	13.9	56
Obstetrics and gynecology	19.1	44
Radiology	21.0	46
Ear, nose, throat diseases	11.6	13
Pediatrics	53.4	109
Neurology, psychiatry	25.6	66
Pulmonary diseases, tuberculosis	40.0	58
Opthalmology	42.0	63
Anesthesiology	36.7	44
Dermatology and venereal diseases	57.4	35
Child psychiatry	89.5	34
Public health and work medicine	25.0	42
Other fields	17.8	39

Source: Unpublished statistics collected by Finnish Medical Association.

Table 8: Fields of Specialization of Male and Female Physicians in Finland in 1973

	Percent	
Field of Specialization	Women	Men
Total number of physicians	659	2100
Surgery	1.5	20.1
Internal diseases	8.5	16.6
Obstetrics and gynecology	6.7	8.9
Radiology	7.0	8.2
Ear, nose, throat diseases	2.0	4.7
Pediatrics	16.5	4.5
Neurology, psychiatry	10.0	9.2
Pulmonary diseases, tuberculosis	8.8	4.1
Ophthalmology	9.6	4.1
Anesthesiology	6.7	3.6
Dermatology and venereal diseases	5.3	1.2
Child psychiatry	5.2	0.2
Public health and work medicine	6.4	6.0
Others	5.9	8.6

The percentage total is more than 100 since some physicians specialize in more than one field.

The earliest data from Norway are from 1946. They show that women medical doctors have avoided the jobs of district physicians in the countryside, but to a fairly large extent have chosen rural institutional positions. There is practically no difference in the proportion of women among private practitioners and employed medical officers, except the above. This lack of difference in the percentage of women among physicians working outside and inside institutions can be seen also in the Norwegian statistics from the year 1972. There are only two noticable exceptions from the average in the proportion of women: the proportion of women participating in medical research and teaching is low, and their economic inactivity rate is high.

In Sweden the percentages of women are very low among medical officers in both rural and urban areas. There are only a few women at somatic hospitals, too, but quite a large number at mental hospitals. In private practice, i.e., "other physicians," the proportion of women is higher than in the total medical profession.

Also in Finland there are more women among private practitioners than among institutionally affiliated physicians. As in Sweden and Norway, the posts of medical officers, teachers and researchers are heavily dominated by men. Public clinics and schools hire more women physicians to take care of their clients, students, or workers, than do private enterprises.

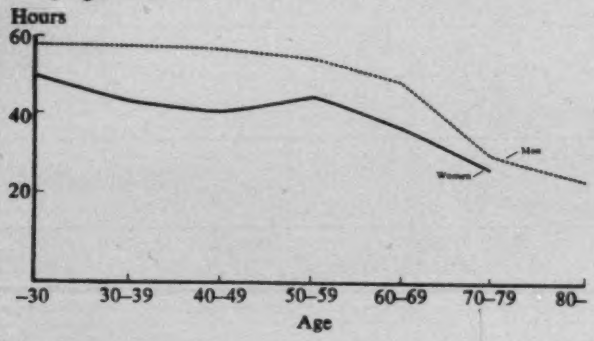
The proportion of private practitioners of the economically active physicians who are not institutionally affiliated in Finland is very low—in 1970 only 9 percent. Most male but not female physicians, however, combine a hospital or other post with practice. In 1962 two-thirds of the male physicians but only less than half of the female ones had taken a double work load as an employee and a private practitioner. Almost forty percent of the women but about twenty percent of the men had an institutional work position only. (Table 12)

Contrary to the situation in other Scandinavian countries, there are less women among private practitioners (independentfi physicians) than among employed physicians in Denmark. The situation of the Danish physicians is similar to the situation of dentists in three of the four Scandinavian countries studied. In Norway, Sweden and Denmark the proportion of women is much higher among employed than among independent dentists. Finland is the only exception in the opposite direction, but the sex difference there is very small. In Denmark, Norway and Sweden women dentists seem to prefer the security and fixed working hours of a school or other public health care instead of the independence of a private practice.

Work Load of Male and Female Physicians and Dentists

The average weekly working time of female physicians in Norway is 12 hours shorter than that of male physicians—43 vs. 55 hours. (Table 14) The sex difference, at least in Norway, is largest at the child care age, from 30 to 49 years.

Figure 5: Average weekly working hours of economically active male and female Norwegian physicians, by age: 1972



There are some survey data about the working hours of Finnish physicians, too. According to Haavio-Mannila and Jaakkola [3] the weekly number of working hours of practicing non-hospital women physicians was eight hours less than that of men. For hospital physicians with practice the difference was five hours. By 1967, the difference for practicing hospital physicians was only two hours. In this last group, the work week of male physicians had been reduced from 55 to 50 hours, that of female physicians from 50 to 48 hours. The working hours of all physicians thus had clearly declined, and in particular the previously overworked male physicians had more leisure time. It appears that the difference between the sexes in this respect is lessening as the work load decreases.

In the same report it was assumed that the shorter work week of women physicians is due to their home-care obligations. In the hospital physician study, the respondents were asked to specify their marital status. Of the men, practically all were married, so that they are not included in the table below. The work load of women in different marital statuses was as follows:

Marital Status	Weekly Work Hours	(N)
unmarried	44.8	(41)
married	43.2	(64)
widowed or divorced	52.1	(11)

The difference between the married and unmarried women was only 1.6 hours. Widowed or divorced women physicians, on the other hand, worked very long hours. Household obligations alone did not suffice to account for the shorter work week of women, since unmarried women physicians also worked fewer hours than men physicians.

According to another Finnish survey by Eskola and Haavio-Mannila [4] on sex roles in six academic professions in 1968, the weekly working hours of male physicians were 51.2 and of female physicians 48.4 hours. The difference was thus 2.8 hours. Male physicians spent in addition, 12.2 hours and female physicians 9.3 hours per week in activities related to work: studies, meetings, preparing articles or speeches, etc. When asked, women preferred shorter working hours than men. Only eight percent of women but 16 percent of men considered a more than 40 hour working week as ideal. Thirty-nine percent of the women and 30 per-

Table 9: Economically Active Male and Female Physicians and Dentists in Finland and Norway: 1970 & 1972

	Women		Men	
	Number	Percent	Number	Percent
		Physicians		
Finland 1970	1,125	93.0	2,856	94.0
Norway 1972	688	87.0	5,014	96.0
		Dentists		
Finland 1970	1,691	90.0	683	96.0

Sources: Official Statistics of Finland 1970 VI:0:104, Population Census, Vol. IX and VII A.
Official Statistics of Norway 1972 A 538, Statistics on Physicians 1972.

Table 10: Occupational Status of Norwegian Physicians by Sex and Age: 1972

	Percentage of Economically Active Physicians								
		Age							
	Total	Under 30	30-39	40-49	50-59	60-69	70-79	80 & Over	Average Age
Males	96.0	96.0	99.0	99.0	99.0	96.0	70.0	31.0	45
Females	87.0	90.0	92.0	91.0	94.0	80.0	45.0	14.0	42

Source: Official Statistics of Norway, 1972 A 538, Statistics on Physicians 1972.

Table 11: Number and Proportion of Women Among Physicians in Different Occupational Positions

Norway 1946	Whole Country		Cities		Countryside	
	Percent	Number	Percent	Number	Percent	Number
Private practice	9.0	117	10.0	74	8.0	45
District physicians, physicians at state hospitals	6.0	38	10.0	20	4.0	17
City physicians, other physicians at communal institutions	9.0	58	8.0	29	12.0	33
Assistant physicians at private clinics	8.0	7	8.0	3	8.0	4

Source: Official Statistics of Norway, Folketellingen in Norge 1946, Yrkesstatistikk.

Norway 1972	Percent	Number
Administrative and perventive medicine	11.0	20
Health work outside institutions	12.0	293
Health work in institutions	12.0	323
Medical research and teaching	4.0	13
Other medical work	14.0	7
Not economically active	35.0	89
Unknown economic activity	18.0	13

Source: Official Statistics of Norway, 1972 A 538, Statistics on Physicians 1972.

Sweden 1955 and 1962	1955		1962	
	Percent	Number	Percent	Number
Total		638		108
Medical officers	2.0	10	3.0	16
City and borough medical officers	2.0	4	3.0	7
Physicians at somatic hospitals	7.0	83	11.0	319
Physicians at mental hospitals	22.0	51	34.0	100
Professors, etc.	—	—	1.0	3
Other physicians	16.0	423	10.9	647

Source: Official Statistics of Sweden, Halso-och sjukvard 1955, 1962.

Denmark 1970	Percent	Number
Total	18.0	1345
Independent physicians	12.0	314
Employed physicians	21.0	1019

Source: Official Statistics of Denmark 1974: VII, Folke-og boligtaellingen 1970. Beskaeftigelse og erhverv.

Finland 1962	Percent	Number
Physicians at hospitals	21.0	230
City and municipality medical officers	16.0	68
Private practitioners	29.0	89
Physicians at schools and public clinics	53.0	49
Physicians at factories and other enterprises	14.0	10
Teachers and researchers	10.0	13
Others	25.0	18

Source: Haavio-Mannila and Jaakkola 1970, p. 12.

Finland 1970	Percent	Number
Independent physicians	36.0	140
Employed physicians	26.0	1073
Total	27.0	1221

Source: Official Statistics of Finland, Population Census 1970, VI A, Education.

cent of the men preferred a flexible, varying length for a work week.

Women dentists also work fewer hours than their male colleagues. Sixty-eight percent of the men but only 39 percent of the women dentists in Finland worked more than eight hours a day in 1965 when many (31 percent) of the Finnish dentists still worked six days a week.[5]

Sex differences in work hours are larger in Norway than in Finland and also larger in the more traditionally female profession of dentistry than in medicine. When the total work load of physicians diminishes, the sex difference seems to decrease also. Women can work as much as men in their profession if they need not totally exhaust themselves as has been the lot of men in countries where lack of physicians has made their work load almost unbearable.

Table 12: Type of Work Place of Male and Female Physicians in Finland: 1962.

Type of Work Place	Women		Men
Total number	628		2128
		Percent	
Institution and practice	48.0		67.0
Institution only	39.0		21.0
Practice only	8.0		7.0
Not economically active	5.0		5.0
	100.0		100.0

Source: Haavio-Mannila, Elina. *Laakarit tutkittavina.* Research Reports, Institute of Sociology. University of Helsinki, No. 41, 1964, p. 12.

Sex Differences in Income

Partly as a result of the shorter work hours, incomes of women physicians are lower than those of men. The average earnings of female physicians in Finland in 1968 were only 63 percent those of men. This proportion is approximately the same as in other academic male-dominated fields like law, engineering, architecture, and forestry.[6] At the same time women in industry earned about 67 percent of the earnings of men. Compared with the incomes of the other academic groups, women physicians were well off. Their incomes were better than those of male foresters and agronomists, and not much below the incomes of male lawyers and engineers. The income level of physicians in general is very high in Finland.

Part of the difference in the incomes of men and women can be explained by referring to the shorter working hours of women. According to the above mentioned survey, when the working time was controlled, women physicians earned 66 percent of the incomes of men. Their lower incomes are mainly due to their inferior occupational status. Only 11 percent of the female but 32 percent of the male physicians in Finland considered themselves to be in a leading position. Seventeen percent of women but only 8 percent of men physicians classified themselves as lower status employees.

Table 13: Number and Proportion of Women Among Dentists in Different Occupational Positions.

	Whole Country		Cities		Countryside	
Norway 1946	Percent	Number	Percent	Number	Percent	Number
Independent dentists	12.0	148	14.0	95	10.0	56
Employed dentists	67.0	163	72.0	93	63.0	72

Source: Official Statistics of Norway, Folketellingen i Norge 1946, Yrkesstatistikk.

	1954		1962	
Sweden 1954 and 1961	Percent	Number	Percent	Number
Total	25.0	975	26.0	1368
Dentists in public dental care	41.0	307	40.0	595
Other active dentists	20.0	603	18.0	640
Inactive dentists	59.0	80	26.0	120

Source: Official Statistics of Sweden, Public Health (and Sick Care), 1954 and 1962.

Denmark 1970	Percent	Number
Total	38.0	1264
Independent dentists	21.0	381
Employed dentists	57.0	861

Source: Official Statistics of Denmark. Folke-og boligtaellingon 1970. Beskaeftigelse og erhverv.

Finland 1970	Percent	Number
Total	70.0	1679
Independent dentists	72.0	1112
Employed dentists	67.0	569

Source: Official Statistics of Finland, Population Census 1970, VII A, Education.

Sex Roles in Medicine and Dentistry as an Example of the General Sex Role Differentiation in a Country

In Scandinavia, women are represented in medicine and dentistry most numerously in Finland and least so in Norway. Denmark and Sweden are between these extremes. Also sex differences in the economic activity and work load of physicians indicate that equality of the sexes is more pronounced in Finland than in Norway.

This result is congruent with other data on sex roles in these countries. According to the Scandinavian survey on welfare and need-satisfaction in 1972 by Erik Allardt,[7] the economic activity of Finnish women is highest and that of Norwegian women lowest in Scandinavia. (Table 15) The general educational level of Finnish women compared to that of men is high, too, whereas in the other Scandinavian countries this sex difference is very small. Vocational training in Finland is as common among men as among women. In the other countries, especially in Norway, men more often than women have received some vocational training.

The position of women in medicine and dentistry is thus connected with the general educational and occupational activity of women. Women's participation in the traditionally male fields of activity seems to be cumulative: in countries where the general activity level of women is high; women have more interest and opportunities to enter into traditionally masculine health professions than in countries where the sex role expectations favour women's societal passivity.

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Table 14: Average Weekly Working Hours of Economically Active Physicians in Norway, by Sex and Age: 1972

Age	Males Number of hrs.	Total males	Females Number of hrs.	Total females
Total	55	4094	43	505
under 30	58	412	50	65
30–39	58	1176	43	190
40–49	57	711	41	79
50–59	55	837	45	110
60–69	49	765	37	45
70–79	29	181	26	14
80–over	23	12	44	2

Source: Official Statistics of Norway 1972 A 538, Statistics on Physicians.

Table 15: Education and Economic Activity of Men and Women in Scandinavia, by Country: 1972.

	Denmark		Finland		Norway		Sweden	
	Men	Women	Men	Women	Men	Women	Men	Women
Total Number	497	498	477	517	496	509	497	508
Education	percent		percent		percent		percent	
More than primary general education	29.0	30.0	22.0	31.0	41.0	39.0	40.0	45.0
Some vocational training	38.0	27.0	33.0	34.0	57.0	42.0	46.0	36.0
with academic examination	4.0	1.0	3.0	5.0	8.0	1.0	7.0	3.0
Economic Activity								
Full-time employment	79.0	33.0	64.0	51.0	75.0	20.0	70.0	26.0
Part-time employment	8.0	17.0	15.0	12.0	7.0	11.0	16.0	28.0
Student or housewife	9.0	41.0	12.0	29.0	13.0	64.0	12.0	42.0
Not able to be employed (illness, unemployment)	4.0	9.0	8.0	9.0	6.0	5.0	3.0	4.0
Total percent *	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* Columns do not add up to 100% due to rounding.
Source: Allardt 1975.

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Appendix: Physicians and Dentists in Selected European Countries on Dec. 13, 1968, per 100,000 Inhabitants

Physicians per 100,000 Inhabitants	Dentists per 100,000 Inhabitants
225 USSR	81 *Norway*
199 Czechoslovakia	80 *Sweden*
179 Austria	68 *Denmark*
178 Bulgaria	52 Germany Fed. Rep.
177 Italy	52 *Finland*
173 Hungary	43 Greece
167 Germany Fed. Rep.	43 Iceland
155 Belgium	40 Switzerland
149 Greece	39 France
147 Malta	39 Poland
145 *Denmark*	39 Germany Dem. Rep.
144 Germany Dem. Rep.	38 Czechoslovakia
141 Romania	37 Bulgaria
139 Poland	35 USSR
136 *Norway*	32 Luxembourg
135 Iceland	27 Austria
135 Switzerland	27 Northern Ireland
131 Scotland	26 England & Wales
130 Spain	25 Netherlands
129 France	24 Scotland
127 Northern Ireland	23 Belgium
124 *Sweden*	22 Hungary
119 Netherlands	21 Ireland
117 England & Wales	20 Yugoslavia
104 Ireland	16 Romania
101 Luxembourg	13 Malta
90 Portugal	10 Spain
89 Yugoslavia	7 Turkey
89 *Finland*	7 Albania
59 Albania	1 Portugal
37 Turkey	

Source: Official Statistics of Finland XI 1970, Public Health and Medical Care.

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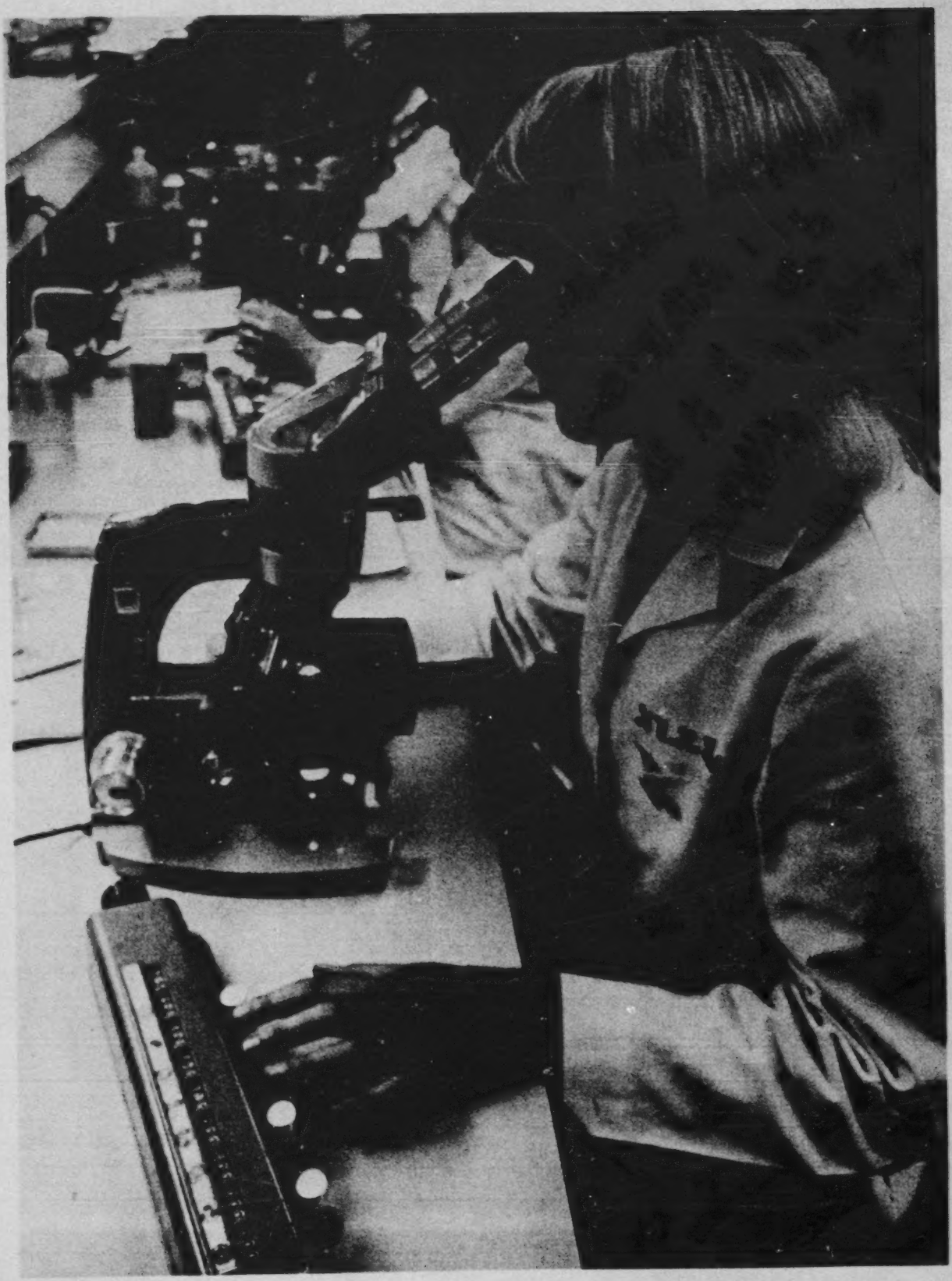

Approaches to Correct the Underrepresentation of Women in the Health Professions

A U.S. Response to the Scandinavian Experience

Estelle Ramey, Ph.D.
Professor, Department of Physiology and Biophysics
Georgetown University Medical School
Washington, D.C.

The first comment I would like to make about all the presentations and the entire conference is that they are indicative of the times—i.e., that this meeting is being held at all in the United States. In the past, the title "International Conference on Women in Health" would probably have been taken to mean a conference of women's ailments, of which, of course, we know they have many. And so like International Women's Year, while it is only a small step forward, it is an important one, since all the rest of the years preceding have been International Men's Years.

The thing that is outstanding in all presentations about women in the health professions throughout the world is the extraordinary similarity of the problems. In the excellent paper by Dr. Elina Haavio-Mannila, even in those countries where women represent a very large portion of the health care delivery system they do not, in general, occupy anywhere near that percentage in what might be called the decisionmaking roles in medicine or dentistry.

Some of you may have seen a first-class article by Dr. Navarro,[1] in a recent issue of the *New England Journal of Medicine*, which was a study of the power structure of health care delivery. The figures are appalling. For the first time, in my experience, Dr. Navarro not only listed what we already know, that there is only a very small percentage of women in health care delivery in the U.S. at the top professional levels, but he addressed the question of the number of women in those parts of the system in which the important decisions are really made. If you look at his graphs you had best use a magnifying glass to find part of the bar that is labeled "Female". It is even more miniscule in dentistry.

I am also amused at figures showing the increase in women in the dental schools as percentage increments over past years. When you start from one-tenth of one percent you have no place to go but very far up.

In this country, women in medicine have had a disheartening history. Elizabeth Blackwell, who got the first medical degree in 1849, had an interesting experience in medical school. She was admitted to the school only with great difficulty, and then to everyone's astonishment, (in 1849 women were considered noneducable). After a short time, the Dean of the School, Dr. Charles Lee was so impressed with her outstanding performance that he predicted that in 10 years, by 1859, one-third of the entering class in medical schools in this country would be women.

Well, I hope he was a better doctor than a predictor, because we are nowhere near that in 1975.

Nevertheless, in the United States, in my experience 51
in the feminist movement, the most remarkable educational advance in professional education for women has come in that bastion of male privilege in this country, the medical schools. In terms of percentage increase, we are talking about very significant numbers of women admitted to medical school since 1970.

At the turn of the century, in 1900, somewhere on the order of about four percent of medical students were women. By 1960 we had skyrocketed to about six percent. This took 60 years. In the decade between 1960 and 1970 the pace was still slow and we ended up in 1970 at about 8.7 percent. Then suddenly we began to see an extraordinary increase in women's admissions. The entering class of 1974-1975 throughout the country was about 22 percent women.[2]

The reasons for this, I think, can be attributed to major and rapid changes in the society, including the feminist movement. New birth control techniques, increasing numbers of women in the colleges and a changing economy, all contributed to a change in women's goals.

Nevertheless, despite our predictions that these gains will go even higher, one is forced to conclude from the Russian and Scandinavian presentations at this conference that mere numbers of women, higher actual numbers and percentages of women in health care delivery, even at top professional levels, do not necessarily predict an increase in the involvement of women in the decisionmaking in medicine. This is a highly critical area, because in neither of these papers is there any great evidence that the role of women at the very top is anywhre near proportionate to their representation in terms of numbers.

In Russia, for example, only 10 percent of the members of the National Academy of Medical Science are women, whereas 70 percent of the doctors there are women. In Finland, where about 25 percent of the doctors are women, their representation at top levels is far below what one would predict.

The reason this is important is that I am told constantly in arguments about affirmative action that, when there is a very small pool of trained females you can anticipate only a very small percentage of females

in top status roles. This would suggest that as we increase our numbers we are going to increase our power. That may or may not happen, but it has certainly not been an inevitable result of increasing numbers. This is very important for those of us who are involved in training for delivery of health care at top levels or at any level.

You will also notice that in all countries mentioned, virtually 100 percent of nurses are women and that these health practitioners have a relatively low status and low income, despite the fact that they provide an absolutely vital segment of the health care team.

My curiosity has been aroused in the United States by the attitude of women themselves towards medical or dental school admissions. The point I would like to make to you is that in this country it was unnecessary
52 for many, many years to discriminate against women on admission committees of these professional schools. You didn't have to bother. Women did it for themselves. They just didn't apply.

As short a time ago as 1972 at Duke University, a study showed that in the freshmen undergraduate class, about 26 percent of the women and about 30 percent of the men indicated an interest in going to medical school.[3] By the senior year that 30 percent of men had dropped to something like 22 percent and for women had dropped to about five percent. Furthermore, of those accepted into medical school, a much higher percentage of women applicants decided not to go.

One must ask the question, Why? What special pressures are there on even such self-selected women? In most countries with our economic structuring, it is the women from rich families who have an opportunity to get advanced education and to go on to medical and other schools because they have available the household help that has always been necessary for a woman to maintain both a home and a professional career. In this country it has not worked out that way. Our top performers in terms of seeking professional careers have not come from this privileged class.[4]

Again, one must ask the question, what is different about the American culture? When Patricia Graham did an article for the journal *Science* on "Women in Academe", she pointed out that in the U.S. women who elect a career in science, including the health sciences, tend to come largely from families in which the mother is either foreign-born or has been educated in Europe. It may come as a surprise to some of you, that most often the mother of such a woman came from the upper middle-class of the South of the United States or from Boston.[5]

Sometimes class structuring is very important and sexual stereotypes may give way under certain special circumstances to the constraints of class. Elizabeth the First could become Queen of England despite her sex because she was "of the blood". Women can do more nontraditional things presumably, if they are "of the blood" in certain parts of the U.S. where ancestry is still important.

The other thing of great interest in looking at American women in medicine, is a study done in the last two years, which showed that when women applicants are compared to male applicants to medical school, slightly more women than men (by percent are refused admission. The differences are not great.[6]

Nevertheless, there is one important distinction. When interviewed, of the men who were turned down with a C-plus average, 58 percent regarded this rejection as unfair and felt that they were really deserving of admission; but only 20 percent of the women with even higher averages who were turned down, thought it was unfair. They expected to be rejected and more tragically, they seemed to think they deserved nothing better.[7]

I don't believe that American admissions committees need to discriminate. I don't believe that legally they can discriminate against women at the present time. I think it is women themselves in all countries, not only our own, who must look at two facets of the discrimination against them.

One is entry. In Russia the entry of women into the medical sciences as far as freshman class is concerned; is going down while it is rising sharply in this country. It seems to be stabilizing in Finland at the present time, as indicated in Dr. Haavio-Mannila's paper, but this is just the beginning.

The important thing to look to, and I speak now for the United States, is what will happen to these women when they get out of medical school. If we follow the pattern of other countries, women despite their numbers will end up in secondary ranks. At this moment only two percent of all full professors in U.S. medical schools are women. Will that change in proportion to our new numbers?

I am not sure that numbers alone make a revolution in the position of women in society. After all, we are already 53% of the population. I think it behooves those of us who are avowed feminists to examine this phenomenon very carefully. The few people at the top who make the decisions as to money and other resources are the ones who determine the ultimate designation of the power to change society. Women must fight not only for an increase in overall numbers in the health care delivery systems but for proportionate representation in the executive suites.

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Approaches to Correct the Underrepresentation of Women in the Health Professions

A U.S. Response to the Scandinavian Experience

Randy Tillman
Second-Year Dental Student,
University of Pennsylvania,
Philadelphia, Pennsylvania

Introduction

"Isn't dentist a masculine word?"

This was a question posed to me six weeks ago, by a high school girl in her junior year, in a suburban high school outside of Philadelphia. This misconception concerning women in the dental profession, is typical of the college bound high school girl in the United States. It is typical also of the prevailing attitude in this counry, that considers dentistry as a profession more suitable for men than for women.

Certainly the situation of women in dentistry in the Unied States differs significantly from the situation of women dentists in Scandinavia, as just described by Dr. Haavio-Mannila.

Women are represented in the dental profession in much smaller percentages in this country than in the Scandinavian countries just discussed. Whereas in Finland 72 percent of all dentists are women, in Denmark 40 percent, and in Sweden and Norway 30 percent; in the United States, as of 1970, only 3.5 percent of all the dentists were female.[1] Another difference that exists between the Scandinavian situation and the American one, is that while dentistry has always attracted more women than medicine in Scandinavia, quite the opposite has been true in this country. In 1970, 9.3 percent of all practicing physicians in the United States were female—again, compared with 3.5 percent of the dentists. However, as is the case in Denmark and Sweden, the percentage of female dentists in the United States will be increasing. In 1974, 11.2 percent of the first year dental school class enrollment was female.[2]

Women Dental Students

It is evident that in the United States the presence of the woman dental student, in noticeable numbers, is rather recent. Just twenty years ago, dental schools like Harvard, Georgetown and St. Louis did not enroll women.[3] Today, many schools admit giving special scrutiny to their female applicants. Some admissions committees may consider the marital status of the applicant, and whether it is likely that her family duties will inerfere with her education or her practice of dentistry. The schools are, or were, afraid that women are more likely than men to perform poorly in school and that their attrition rate will be higher. Recent studies have shown, however, that the fears of the schools are unfounded, because women perform better scholastically than their male counterparts, and that drop-outs are equally as likely to be men as women.[4]

Most of the studies in the literature conclude that women in dental schools do not have difficulty handling academic and clinical responsibilities, but they may have difficulties in other, non-scholastic areas. Women dental students sometimes report that psycho social problems arise in an all-male environment. Linn [5] interviewed women from three different dental schools, and several discussed problems that arose because they were females in a minority situation. The women dental students said that their male peers often falsely accused them of getting preferential treatment from instructors. The women felt, in fact, that the instructors were sometimes unfair to them, and by advising them to go into traditionally female specialities, tried to limit their career options. The women students interviewed said they were often left out of after-school study groups and informal gatherings, which tended to be single-sexed.

A subcommittee on the status of women students at the College of Medicine and Dentistry of New Jersey conducted a survey similar to Linn's in 1972.[6] The subcommittee examined how women perceived their educational experience had been affected by their sex. An attitudinal questionnaire was sent to women medical and dental students and alumnae. The respondents discussed discrimination often, but few reported overt instances. Among those that mentioned feeling discrimination, half reported that the negative attitudes towards women as dentists were more apt to come from male students than from faculty members. However, the women felt that the faculty members were sometimes insensitive to female students. Often, classes started with dirty jokes, as well as anti-feminist jokes, and the women were expected to laugh at both. The respondents said that they sometimes felt they were expected to "prove" themselves more than their male counterparts. Overall, however, 77 percent of the respondents felt that they encountered no more difficul-

ties than the men in their class; and 87 percent said that if given the choice, they would choose a career in the health profession again.

It has been my experience as a dental student, that the instances of sex discrimination within the dental schools are very covert and subtle. I conducted a survey of eight dental schools last summer, for Region III of the Department of Health, Education, and Welfare, and found that most dental school administrators were not even aware of the sex discrimination that existed within their own institutions. In my dental school class, for example, there are fifteen women out of a class of 162 students.

In preclinical preparatory labs at school, I find that frequently male classmates will tease me about getting preferential treatment from instructors. These lab situations are very stressful, and require long hours of preparation before final projects can be graded. It is very irritating to have worked long and hard on a project, to receive a good grade, and then be told by male lab companions that I only received the grade because I was a girl. In fact, such remarks are more than irritating, for they tend to undermine my professional self-image, at a time when I am trying terribly hard to build up my self-respect as a competent dental practitioner.

Women Dentists

Dr. Haavio-Mannila has discussed the occupational productivity of women dentists as compared to male dentists in Scandinavian countries. It was her observation that in countries where only a few women are active in a profession, the sex differences in economic activity are apt to be larger than in a country which has more women in the professions. This observation would seem to predict that in the United States there would be a substantial sex difference in economic activity of male and female dentists. Unfortunately, to my knowledge, adequate studies have not been undertaken on the subject. The only studies that do exist claim that somewhere between 77 and 85 percent of all women dentists are active professionally.[7 8] However, no comparisons with male dentists are available.

Women dentists in the United States are more likely to specialize than men. Thirty-one percent of women dentists specialize, as compared to ten percent of men.[9] Furthermore, it was found that the two most popular specialities for women dentists were pedodontics and orthodontics; the two most popular specialities for men are orthodontics and oral surgery.

One study, conducted by Linn, found that women dentists are more likely than men to change their practice location.[10] Obtaining State licensure was a major problem for many of these women dentists. Approximately 38 percent of the women dentists interviewed said that they had interrupted their dental careers one or more times since graduation. These interruptions were usually caused by pregnancy, family demands, or husbands changing their place of work. On the average, the total length of time for all interruptions was four years. It was noted in a study by Talbot, that marital status was the most important factor in determining the professional activity of women dentists.[11] A single woman who had never been married was more likely to work full time. The determinant in the amount of time devoted to dentistry was the presence and age of children.

The difference in practice patterns of male and female dentists in the United States, in terms of working hours per week, income levels, and private versus non-private work, have not, to my knowledge, been researched. Certainly more demographic data are needed to compare and evaluate the sex differences in practice patterns between male and female dentists in in the United States.

Attraction of Women to Dentistry

One may wonder why more women in the United States are not attracted to the dental profession. Strange and Lu [12] conducted a survey of high school students from six different schools across the country to determine their attitudes towards dentistry as a career for women. When the students were asked to rank dentistry in comparison to twelve other professions and careers, dentistry ranked quite low. It was ranked seventh by the boys, and tenth by the girls. In the same study, questions were designed to assess attitudes towards women in dentistry, and it was discovered that only about one-third of the respondents thought dentistry was a good career choice for a woman, and even then, the majority did not feel that a woman could successfully pursue a dental career and still have a good family life. Most of the students believed that women were capable of becoming good dentists, but that they should not pursue a professional career.

Levine suggests that one reason why many girls do not consider dentistry, is that they view it as a masculine profession, because in this country, it is practiced primarily by men.[13] Furthermore, dentistry is involved with the sciences and with mechanical ability, both of which are considered masculine interests in American society. It is often true that small boys are encouraged to play with mechanical devices, while little girls are not. The tendency for boys to do better in the sciences is evident throughout the educational years. Since 1955, National Merit Scholarships have been awarded to 800,000 high school juniors each year; and the girls always do better in English, and the boys excel in mathematics, social studies, and sciences.[14] In the United States, women earn only 30 percent of the bachelor's and master's degrees in the biological sciences, and only 16 percent of the doctorates.[15]

Most reseachers suggest that the concept of the "role model" plays a large part in any individual's choice of career. Most of us, in some way or another, develop our career expectations and participate in daily activities which fit a preconceived role. We tend to pattern this role after another individual whom we respect and with whom we can identify. The woman who considers becoming a dentist (or the man who considers becom-

ing a nurse or dental hygienist) is in a peculiar situation. First, this person lacks the usual stimulus to enter such a profession because of the lack of identifiable role models, and second, once making the decision to enter the unconventional role, must contend with self-doubts about his or her proper place within the role. In fact, it was found by one researcher, that women who enter the dental profession in the United States usually have more than average social exposure to dentists.[16] A greater number of women dentists and dental students reported that a member of their immediate family or other relative was a dentist than did their male counterparts.

Most persons interested in recruiting more women to dentistry feel that women dentists should play a greater role in encouraging other women to enter the profession, thus providing the role model which is now lacking. In addition, it is felt that recruitment efforts should begin during the high school years or earlier, before women have eliminated dentistry as a viable alternative.

Specific suggestions for recruitment efforts might include workshops to be sponsored at the dental schools for women's college advisers and even high school counselors. Also brochures might be published by individual dental schools that are specifically directed at a female audience. Certainly similar measures have been undertaken by the dental profession to increase the representation of other minority groups.

After I researched the admissions programs of eight dental schools last summer, it was my conclusion that there was little evidence of affirmative action programs for women in dentistry. The prevailing attitude among dental school administrators in the United States seems to be that since the enrollment of women has increased steadily over the past five years, it will continue to do so without much intervention on the part of individual schools.

The word "dentist" is not a masculine word in Scandinavia—and should not be in the United States.

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How To Improve The Utilization Of Nurses And Allied Health Support Personnel: The Swedish Model

Inga Johnsson, R.N.
Assistant Head,
National Board of Health
and Welfare
Planning Unit
Stockholm, Sweden

Some Information About Women and Men in the Health Field in Sweden

Women constitute slightly more than one-half of the Swedish population. They represent 40 percent of the labour market, which is to say that there are four wage earning women per six men. Since the beginning of 1960, women have been responsible for the increase in the total labour force. Of the total of four million employees, 650,000 are working part-time, of which 600,000 are women and 50,000 men. Between 1965 and 1973, 250,000 women entered the labour market —the female labour market. There still exists in Sweden one labour market for men and another, with lower salaries and inferior career opportunities, for women. In 1970, 72 percent, that is, almost three-quarters of all wage-earning women, were found in 25 of the 290 classified occupations.

Approximately 225,000 persons, 5.8 percent of the total labour force, were employed in the health field in 1973. Between 1960 and 1970, the number of health care workers increased by 43 percent, between 1970 and 1972, by 14 percent. From 1960 to 1972 the total population in the country increased by 8.6 percent.

The rate of increase in the number of workers differs among the health occupations. As Table 1 shows, the rate of increase was largest among occupational therapists and social workers. Their number increased 300 percent between the years 1960 and 1970. Between 1970 and 1972 the increase in workers was largest among physiotherapists and nurses.

Between 1960 and 1972, the number of physicians increased by 67 percent, dentists by 37 percent, nurses by 92 percent, and other health care workers by 58 percent. In 1960, there were 1,050 inhabitants per physician, in 1970, 760 inhabitants per physician, and in 1972, 620 inhabitants per physician. The proportion between dentists and inhabitants in 1960 was one per 1,470, in 1970, one per 1,200, and in 1972, one per 620.

Looking at the health team, which consists of nurses, physiotherapists, occupational therapists, social workers, practical nurses and nursing aides, in 1960 there were 816 health care workers per 100 physicians, in 1970, 878, and in 1972, 918.

Table 2 demonstrates that although the health field is one occupied mainly by women, the proportion of women to men varies among the different health occupations. Men are found as physicians, dentists, dental technicians, nursing assistants and psychiatrists. The other health occupations are fully dominated by women.

Issues and Approaches to the Utilization of Women in the Health Occupations: Nursing, Allied Health Occupations and Support Services

In view of the short supply of health workers during the last ten years, especially physicians and nurses, it has been necessary to find means to make the best use of available resources and to upgrade knowledge and skills. The problem of short supply of health workers in Sweden is combined with an uneven distribution, which renders the problem even more difficult to solve.

Recruitment: As in all other industrialized countries, the demand for manpower in Sweden varies according to economic fluctuations. It is mainly technical and structural developments and consumption which determine production and, thereby, the need for manpower. The supply of manpower is, however, changing. There can be large variations over a short term. Sweden's labour force totals approximately four million but during the course of a year approximately four and one-half million are part of the labour market at some time.

There may be a manpower shortage in some places while employment opportunities are scarce in others. There exist considerable regional differences, particularly between the northern parts of the country and the rest of Sweden. By using appropriate selective measures, the National Labour Market attempts to facilitate the adjustment of manpower supply and demand to changing conditions.

Employment service, vocational guidance and large vocational training programs: These programs represent the main implement for recruitment. Employment counseling, a part of the general employment service, is very important in the recruitment of health care workers, due to the many fields of specialization, and the variety of qualifications required. The employment

Table 1: Active Health Care Workers
Average Annual Percent Increase: 1960, 1970, and 1972

Occupation	1960 Number	Annual Percent Increase 1960-70	1970 Number	Annual Percent Increase 1970-72	1972 Number
Total	116,510	4.0	167,650	7.0	191,670
Physicians	7,130	4.0	10,560	6.0	11,920
Dentists	5,090	3.0	6,720	2.0	6,990
Nurses	22,050	4.5	34,240	11.0	42,250
Physiotherapists	1,790	4.0	2,600	17.0	3,510
Occupational therapists	210	30.0	660	4.0	710
Social workers	230	30.0	720	10.0	870
Dental technicians	1,850	3.5	2,600	2.0	2,700
Dental nurse/assistant	5,090	4.0	7,500	3.5	8,000
Practical nurses / Nursing aides	32,860	5.0	53,960	7.0	61,450
Nursing assistant in psychiatric care	11,000	3.0	14,950	6.0	16,780
Others	29,210	1.5	33,140	5.0	36,490

Source: Allman Halso- och Sjukvard 1972

counseling organization provides individual guidance and systematic follow-up for all those who request them.

The prevocational practical orientation (PRYO): This is another measure designed to introduce pupils to different occupations and working environments while they are still attending the nine year comprehensive school. The scheme is comprised of three introductory study visits in the eighth year and a compulsory two-week period in the fall term of the ninth year. The practical orientation in the ninth year may be extended to a maximum of 36 days. While PRYO was first introduced in 1960, its present form was initiated in the 1972-73 school year.

Labour market training programs: These programs are provided to solve adjustment problems of individuals, as well as to try to satisfy the demand for trained labour. The programs are comprised of various types of courses, the main types of which are retraining, further training, and refresher courses. The training programs follow curricula adopted by the National Board of Education. During the budget year 1973-74, 8,399 persons took part in labour market training schemes for personnel in the health field. Steps have been taken by the government to lighten the burden of home and family responsibilities for working women. They include facilities for the provision of care for children.

Pre-school Activities Act: Passed by the Swedish Parliament in December 1973, the Act gives small children a statutory right to adequate provisions for their care. "Pre-school" is the term used for activities organized in the form of day nurseries, at which children between the ages of six months and seven years may spend five or more hours a day, and at which part-time groups of children between the ages of three and seven may spend, usually, three hours a day.

Parenthood Benefit: In January 1974, a new regulation came into force under which a benefit will be paid to that parent who will have custody of the newborn baby. The parents may alternate caring for the child. Parenthood benefit is paid for a maximum of 210 days per birth, regardless of how it is divided between the parents.

Along with the measures undertaken by the government, various steps of a specific nature are undertaken by local hospitals, health agencies and other institutions, in order to recruit workers for health care services. For recruitment of those in the health occupations who have been active and are currently inactive, the National Board of Health and Welfare provides manpower data. Through its registers of selected occupations, information on the supply of health care workers in the county, region, or country as a whole, is available. Some health occupations, e.g., physicians, dentists, nurses, midwives, physiotherapists, medical technicians, and practical nurses must submit annually to the Board not only their name, address, age, specialty, number of children under the age of seven, number of months in work, but also the post she/he has held during the previous year, any additional education she/he has had, and any other relevant information. It has been said that there are no other occupations in our society which are as carefully observed as those in the health field.

Housing shortages have, for many years, been one of the factors limiting the availability of nursing personnel. The health authorities now offer modern residential dwellings in the vicinity of—but outside—the hospital grounds. If the workers do not want to rent these flats they are made available to other people.

Retention of Health Care Workers: Health authorities in Sweden are fully aware of the fact that the best way to encourage health care workers to remain in the work force is to offer good working conditions. The working conditions of health occupations are, however, determined by collective negotiation. As they are con-

Table 2: Active Health Care Workers—the Proportion of Female Workers: 1972

Occupation	Total	Female Number	Percent
Physicians	11,920	2,160	18.1
Dentists	6,990	2,010	28.8
Nurses	42,240	41,450	98.1
Physiotherapists	3,510	3,370	96.0
Occupational therapists	710	670	94.8
Social workers	870	800	92.0
Dental technicians	2,700	500	18.5
Dental nurse/assistants	8,000	8,000	100.0
Practical nurses / Nursing aides	61,450	59,790	97.3
Nursing assistant in psychiatric care	16,780	10,560	62.9

Source: Allman Halso- och Sjukvard 1972
Landstingsforbundet 1972

Table 3: Total Salary for Health Care Workers—Average Income Per Month: 1973

Occupation	Sw. Cr.*
Average income all occupations	3,220
Physician (head)	13,200
Physician with specialist qualification	10,050
Physician without specialist qualification	8,260
Physician district	10,390
Dentist	5,780
Nurse (head)	3,360
Nurse (assistant)	3,020
Physiotherapist	3,330
Occupational therapist	2,730
Technician	3,070
Technician, laboratory	2,780
Social worker	3,510
Dental hygienist	2,510
Dental technician	3,610
Dental nurse/assistant	2,490
Practical nurse	2,770
Nursing assistant in psychiatric care	2,760
Nursing aide	2,440

Source: Landstingsforbundet
* $1 = 3.94 Sw.Cr. (arithmetic mean)

Table 4: Months Employed—Nurses and Medical Technicians: 1968, 1970, and 1972

	percent employed more than 9 months	percent employed less than 9 months	percent inactive
Nurses			
1968	35	37	28
1970	38	37	25
1972	34	48	18
Medical technicians			
1968	50	37	13
1970	42	37	21
1972	42	43	15

Source: Sjukskoterskekaren, 1972
Assistentkaren, 1972

Table 5: Achievement—Days of Work, of Nurses and Medical Technicians, in the Years 1968, 1970, and 1972*

Achievement of	Days of work 1968	1970	1972
100 nurses	48	49	52
100 medical technicians	51.3	55	59

* Reflects the extent to which nurses and medical technicians are part-time workers.

nected with those of many other groups of employees, negotiations concerning conditions such as hours of work, night duty, overtime, and premium pay for late-shift work, are conducted in cooperation with professional and trade union organizations. In recent years, the negotiations have been directed toward increases in the salaries of low-income workers in order to bring their salaries to the average income level. The majority of health care workers are women, and these women, like women workers generally, are, to a large extent, employed at lower income levels than men (Table 3). Through the process cited above, these women have been granted their share, and are now approaching a level of income more comparable with the average income. Negotiations are currently in progress for the years 1975 and 1976, and again are concentrated on low-income receivers.

In Sweden there is a reservoir of women educated for health care service who should be brought back into service on either a full-time or a part-time basis. Tables 4 and 5 show the duration of employment and days worked for two occupations—nurses and medical technicians.

The difficulty of combining marriage, childbearing, and family responsibilities with work in hospitals and institutions is a problem. Therefore, efforts have been made to develop part-time employment. This has, however, presented special problems because very often the part-time worker can work only during special hours. This causes friction when evening duties and holiday work fall upon the other members of the health care team. The increasing number of health care workers who leave their work for family responsibilities underlines the need for a careful analysis of the working pattern and the shift arrangements in health care services. Such an analysis has been initiated.

Best Use of Available Resources: The basic question underlying the problem of effective utilization of health care workers is "Who can do what and for whom?" In order to be able to conserve nursing skills for where they are most needed, and to find out how reassignment of activities among nursing personnel and others could be made, a country-wide evaluation of nursing activities and activities performed by different groups of nursing personnel was undertaken. The study covered approximately 1,200 different units, a sixth of all wards, a third of all out-patient units, all operating-theatres, all maternity units, all laboratories, and all x-ray units.

The study revealed several factors influencing the staffing and the nursing hours devoted to patient care. As a result, today there are a number of services and facilities established and available in Swedish hospitals and institutions: clerical service, messenger and delivery service, and housekeeping and dietary departments. Both women and men were placed in pools of personnel to perform these activities.

The study report which also revealed possibilities for utilization of auxiliary staff to relieve nurses of activities not requiring their skills, was distributed by the government for comment to health authorities, pro-

fessional organizations and labour unions which would be affected by the proposals made in the report. The Ministry then drew up the resolution and submitted it to the Parliament. An organized plan of assignments for practical nurses, nursing aides, and ward clerks was then established. Education and systematic employment on a national level were initiated for these occupations.

Investigations into activities from which nurses could relieve physicians (general practitioners) should also be mentioned. The information received from the investigations has been used for experiments which are going on in a Community Health Center. The experiment will be described later.

Current assessment of the character of the health care services and the personnel required to provide
60 them is necessary. New knowledge must be acquired regularly, and new techniques are continually being developed. As medical practice changes, the functions and activities of different health care workers will change.

To increase the efficiency of health manpower utilization, studies of different kinds are undertaken. They may be conducted for a single unit, a hospital, a health agency, or institutions in a county. They are mostly performed by personnel employed by the county. Twenty-one of the 23 counties have managerial units with their own staff, i.e., people who are expert in planning and directing activity studies. For consultation services the counties can rely on Spri, the Institute for the Planning and Rationalization of Health and Welfare, sponsored by the Ministry of Health and Social Affairs, the Federation of County Councils, and three municipal councils. The Institute has departments for planning, organization, construction, equipment, and facilities. The managerial department provides assistance to counties in outlining studies of different kinds.

Upgrading Knowledge and Skills: The way to upgrade the knowledge and skills of health care workers is that applied to workers in other fields—inservice education. This education is the responsibility of employers, i.e., the counties. It is stated by regulation that physicians, midwives, public health nurses and physiotherapists must undergo further education at regular intervals.

In order to provide service to the counties in this respect a special department was established within the Federation of County Councils to provide educational programs of general interest and value to all counties. Assistance is made available to counties which want to develop new programs and new approaches for improvement of their inservice education. The department is also responsible for the development of new teaching-aids and equipment. The program for each county is, however, based on local needs, and much effort is put into the programs which intend to prepare the employees for their work.

One example: Until recently, patients in acute coronary distress were treated in the general intensive-care unit. With the development of electronic monitoring machines and other equipment, a separate unit where both staff and equipment would be immediately available was established for the treatment of acute coronary diseases. When the program of cradiac intensive care was initiated, there were almost no nurses who had the necessary preparation for working in the unit. It became the responsibility of the physicians in the cardiac unit to provide the necessary instruction to make delegation of tasks possible. When the physicians are assured that the necessary degree of competence has been attained, they relinquish some of their responsibilities to the nurses within the unit.

When another cardiac unit was to be established, there was a demand for nurses with the necessary preparation. The physicians in the special branch of the medical association urged that the preparation of nurses in cardiac intensive care be provided as rapidly as possible. The initiative led to the establishment of regular courses which are added as instructional modules to the present program of post-basic education in intensive care nursing. The delegation of activities by the physician to the nurse was subsequently followed by additional preparation of the other health workers involved. This preparation also consisted of modules added to earlier education of practical nurses.

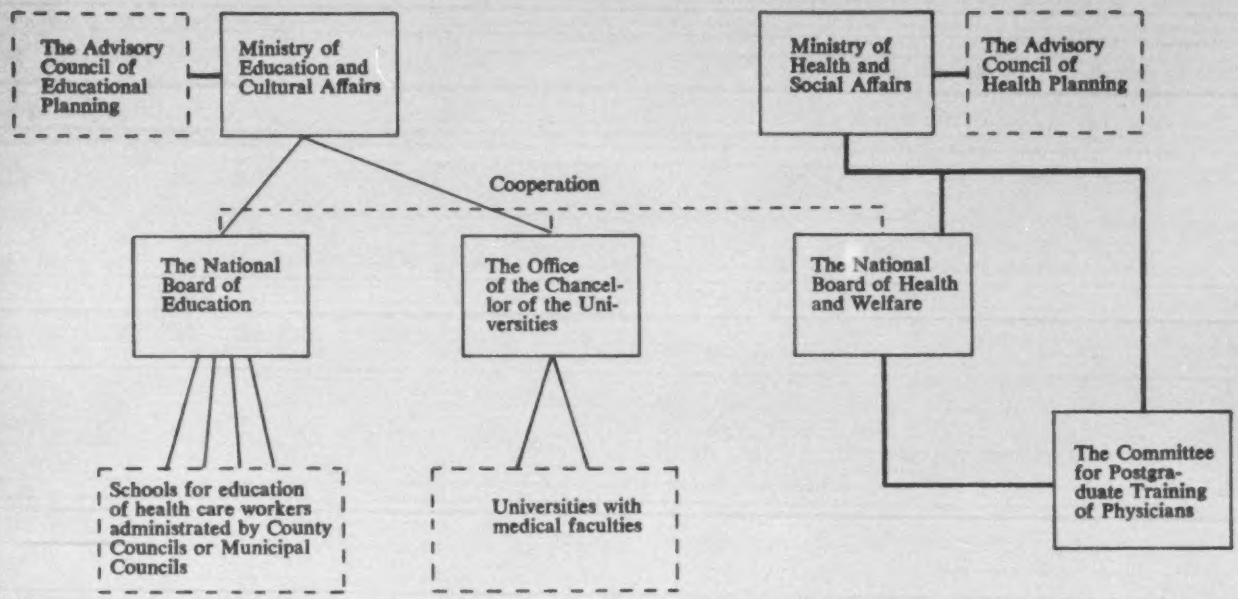
Methods to Improve Utilization of Health Care Workers: Specifically, New Tasks for Nurses and More Responsibility to Nurses in Primary Care

Foreigners who study the Swedish health care service are often surprised at the Swedish nurse, who performs activities that in other countries would be done by physicians. This has been the case for nurses working in hospitals, but more so for nurses engaged in health care services outside the hospitals.

Government, health agencies, county councils, professional organizations and labour unions can propose innovations in health care delivery. It may be the Parliament, through a motion presented by a member, which decides upon an extension of service in relation to abortions, or a health agency or institution which has the availability of one group of health care workers and inavailability of another, and wants to provide essential service through special arrangements, or a branch within the medical association which can see an expanding role for X-ray technicians, or the labour union which wants to draw the attention to the fact that practical nurses are not used to the best advantage. These circumstances call for a mechanism for the rearrangement of work and a link between potential utilization and education.

Education for health care personnel is, in the first instance, the responsibility of the Ministry of Education and Cultural Affairs on one hand, and the Ministry of Health and Social Affairs, on the other. Under these ministries, one will find various independent administrative departments (Figure 1) dealing with matters relating to the education of health care workers, e.g., the National Board of Education, the Office of the Chancellor of the Swedish Universities (UKA) and the National Board of Health and Welfare. In addition to

Figure 1: The State Organization For Education Of Health Care Workers


The Advisory Council of Educational Planning
Ministry of Education and Cultural Affairs
Ministry of Health and Social Affairs
The Advisory Council of Health Planning
Cooperation
The National Board of Education
The Office of the Chancellor of the Universities
The National Board of Health and Welfare
The Committee for Postgraduate Training of Physicians
Schools for education of health care workers administrated by County Councils or Municipal Councils
Universities with medical faculties

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these departments, there are advisory bodies to the Ministry of Education and Cultural Affairs and the Ministry of Health and Social Affairs, namely, the Advisory Council of Educational planning and the Advisory Council of Health Planning. The latter is responsible for the coordination of all health planning in Sweden.

All curricula for health care personnel are approved by the National Board of Health and Welfare, which also is responsible for the planning of health care workers for the country as a whole. The education of physicians and dentists is administered through the Office of the Chancellor of the Swedish Universities (UKA). The National Board of Education is the central administrative body which directs and, in cooperation with the National Board of Health and Welfare, plans education for most health care workers. The schools for education of these workers are administered by county councils or municipal councils.

The trend is to establish combined schools for the education of various health occupations. There can be up to 50 different educational programs in the same school, i.e., basic nursing education, post-basic nursing education, practical nurse education, nursing aide education, X-ray and laboratory technician education, etc. All schools throughout the country have the same curriculum for each occupation and are organized along the same lines.

There are several parties involved in the development of curricula for health care personnel. For this reason "rules of procedures" for planning have been established. The draft of a curriculum, whether it is new or a change in an existing one, is distributed for comment to the National Board of Health and Welfare, to health authorities, professional associations and labour unions which will be affected by the proposed education. Through this pattern of collaboration the time for implementation of a curriculum is considerably reduced.

Maternal and Child Health Care

The activities in maternal and child health care are carried out according to plans determined by the National Board of Health and Welfare.

Maternal Health Service: Maternal health care is provided at local health centers. It includes prenatal care, postnatal care and contraceptive counseling. Some 94 percent of all expectant mothers utilize the health care system. Every pregnant woman should visit a physician at least three times for prenatal care and at least once for postnatal care. Midwives and public health nurses with postgraduate education in maternal health care are appointed at these health centers. They have hours for visits at announced times. They take part in prenatal and postnatal care, they arrange courses to prepare parents for childbirth, and they give contraceptive advice.

At the initial visit, the pregnant woman is screened by a physician. Those who are regarded as normal cases are assigned to midwives or nurses from whom they will receive care as long as the course of the pregnancy remains normal and until the woman enters the hospital in labour. Pregnant women in high risk groups are cared for by physicians.

Visits in 1972 to Physicians and Midwives (Average Visits for The Whole Country)

	Physicians	Midwife
Visits per expectant mother	4.1	9.0
The midwives also make home visits to expectant mother. Home visit (average for the whole country) is 0.2 per expectant mother		

Source: Allman Halso- och Sjukvard 1972

For a long time it has been the responsibility of midwives to provide contraceptive advice to both pregnant and non-pregnant women. The new law concerning abortion (1974) implies that advice is available upon request about the termination of pregnancy. The maternal health center has developed into an institution to which one turns in need of help both to avoid pregnancy and during pregnancy, irrespective of whether one wants to carry on or terminate the pregnancy. The midwives are trained in and take care of the applications of some technical devices for family planning. Gynecological health control of all women in certain age groups as well as control of single women is undertaken by midwives.

Child health service: Child health care is provided at local health centers. Child health care is entirely voluntary, but it is estimated that 99.9 percent of newborn children are covered. The aim of child health care is complete health supervision and detection of handicaps of all children between birth to school age. Nurses with post-graduate education work as members of the team in the health centers. The health supervision of children (excluding those with abnormalities) includes examinations by physicians four to seven times during the first year, twice during the second year, and once a year for all other ages.

Visits in 1972 to Physicians and Nurses (Average for the Whole Country)

Visits	Physician	Nurse
During the first year	4.7	4.3
second year	1.6	1.2
third to seventh year	0.8	0.6
The nurse also makes home visits. Home visits (average for the whole country) are		
During the first year		2.7
second year		0.5
third to seventh year		0.4

Source: Allman Halso- och Sjukvard 1972

Public Health Care (District Care)

The range of activities of the public health nurse/district nurse varies depending on whether she works in an urban or rural area. In the rural areas, her activities include maternal and child health care as well as school care. The district nurse works practically independently, particularly in sparsely populated areas. The district doctor is, however, her formal supervisor.

Activities of District Nurses: 1972

	Districts		
	Urban	Other	All
Number of district nurses	365	1,530	1,895
Number of home visits	475,521	1,159,900	1,635,421
Sick care (exculding care for long-term patients) per district nurse	1,303	758	2,061
Care to long-term patients	121,886	206,074	327,960
per district nurse	334	135	173
Health care	12,723	339,955	352,678
per district nurse	35	222	186
Child health care	—	266,020	266,020
Number of visits to district nurses			
Sick care (excluding long-term)	484,014	1,404,102	1,888,116
Care to long-term patients	7,387	9,100	16,487
Health care	40,300	567,929	608,229

Source: Allman Halso- och Sjukvard 1972

Occupation

In the course of time, district nurses become well acquainted with the neighborhood where they work. They are well informed about individual families, their living and working conditions, which have general bearing upon their attitudes toward child-rearing and health practices.

In addition to their responsibility for problems of physical health, they are very often called upon to meet the needs of mentally disturbed patients. With a new structure of the health care service, the responsibilities in this respect will increase. Their responsibilities in total family health will call for an exploration of the staffing pattern in the health care service. The future will demand selective reassignment of activities from the district nurse to others. Studies carried out by Spri indicate possibilities of using auxiliary nursing personnel in conjunction with district nurses.

Community Health Centers

As mentioned earlier in this presentation, studies have been undertaken which show that nurses can accept activities which today are performed by physicians. To further investigate these findings, research projects have been initiated. The purpose is to see if the best use of the general practitioner in health centers is being made, or if any activity can be handed over from the GP to other health care workers.

Special clinics have been organized for such chronic diseases as diabetes, cardiovascular diseases, urinary tract infections, and mental diseases of the elderly. When a patient appears with signs of a chronic disease, he is taken care of by a physician who makes the diagnosis, informs the patient of that diagnosis, and draws up the plan of treatment. The physician starts the treatment and ensures that the expected effect is being achieved. From then on the control procedure becomes the activity of the nurse.

The Clinic for Diabetes

The diabetes clinic is organized with a nurse, a part-time dietician, and social worker in charge. The work

follows a specific program in which the nurse has to see each patient at least every third month. She checks the medical history, informs the patient about the disease and teaches him how to check urine. She performs a physical examination, takes the blood pressure, inspects the feet carefully and conducts neurological examination. Once a year the patient is examined by one of the physicians at the center.

The diabetes clinic has been a success. It has been learned from the clinic that three of the four annual visits to physicians can be handed over to other health care workers, mainly nurses, and that the patient values the close contact with the nurse and the continuous information he receives from her.

Analysis of Issues of Career Ladders Within Health Occupations

For several years, there has been a career ladder in practice within the field of nursing. A career plan is developed through which a person may begin at the entry level as a nursing aid, then move to an increased level of competence as a practical nurse and later on as a registered nurse.

A national committee has recently proposed an educational program through which the registered nurse may reach the level of the physician. All the way up the ladder each new program is built on knowledge obtained through earlier education and experience.

This principle, among others, can be observed in a proposal entitled "Higher Education" presented to the Parliament. The educational organization for future higher education is arranged to stimulate further studies. The intention is to offer every individual a suitable pattern of education. Through this proposal, the present faculties of the universities will be replaced by occupational sectors. Five sectors are proposed, one with programs for education of health care workers. Through these arrangements it will be possible to relate all health occupations to an educational continuum and to create curricula for education of health care workers. It is proposed that those who are to use the trained manpower will have a greater influence on the content of different programs. This structure for future Swedish health care service, with defined responsibility within the health delivery system for development of norms for health care service, will make it possible to lay the foundation necessary to develop new educational programs.

A study of health care service undertaken by Spri included an analysis of functions in different services. Its purpose was to find elements in common which can serve as a basis for the development of modules for education and training. New knowledge and techniques can lead to new modules being introduced into the system. It will be possible to return to the educational system to acquire additional modules. In the case of transfer from one occupation to another, credit will be given for modules previously acquired. Through such an educational system one can expect a greater flexibility, not only in the development, but also in the use of health manpower.

The Effect of Sex Stereotyping of Occupations on Health Care Delivery and Methods to Break Down Such Stereotyping

The present sex roles in Sweden are deep-rooted. The existing pattern of life conditions is impressed upon children while they are growing up. It is reflected in their choice of education and later, in their choice of occupation. Even though the number of women entering the gymnasium has increased during the last decade, the number of those who enter universities for studies, for instance, in medicine and dentistry, has remained almost constant over a period of time (Table 6).

Table 6: Students Admitted to Medical and Odontological Faculties by Sex—in 1960/61, 1965/66, 1970/71, and 1972/73

Faculty	Academic Year 1960/61	1965/66	1970/71	1972/73
Medical				
Total number	491	575	902	1,055
Number women	116	151	227	307
percent women	23.6	26.3	25.2	29.1
Odontological				
Total number	237	273	386	439
Number women	87	115	146	184
percent women	36.7	42.1	37.8	41.9

Source: Utbildningsstatistik 1960-1973
SCB: PM 1974:3
Allman Halso- och Sjukvard 1972

The increase of wage-earning of women during the last decade mentioned earlier has not affected sex segregation or the mechanism behind it. So long as expectations in regard to income and career opportunities are so different between women and men, little change can be expected. The occurrence of two different labour markets in which women and men hardly compete with each other, does not contribute to a dissolution of sex segregation.

As previously stated, women constitute a significant potential for future workers in the health field. From Table 7 it may be observed that students admitted to schools of nursing are mainly women, even though nursing education has been open to men since 1951.

Table 7: Students Admitted to Schools of Nursing by Sex in 1960, 1967, 1970, and 1973

	1960	1967	1970	1973
Total number	1,872	2,871	3,084	2,530
Number men	—	—	217	317
Percent men	—	—	7.0	12.7

Source: Utbildningsstatistik 1960-1973
SCB: PM 1974:3
Allman Halso- och Sjukvard 1972

During the next decade, a slight decrease is expected in the total supply of manpower. An increase is foreseen among married women due to a higher rate of employment and to immigration. A decrease is, however, expected in the supply of male manpower due to lower age groups and improved conditions for retirement. It seems, therefore, to be necessary to rely

on female manpower in the health field in the near future.

A commission, which since 1972 has examined the problem of equality/parity in rank between women and men in Sweden, has undertaken a survey this year of the conditions of life of Swedish males and females. It is hoped that the findings can be translated into specific measures and initiatives.

Worker Activism: The idea behind "workers participation" has deep roots in the history of the labour movement. Since 1946, the Swedish work council system, an agreement between the Swedish Employers' Confederation and the trade unions, has been in force. The work council was supposed to be a "medium for information and joint consultation between the management and the employees through their trade unions' organizations."

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Today, the trade unions are involved in discussions concerning the role of these councils. It is argued that work councils must have the right to decide on central questions, such as personnel administration, organization and production. One way in which workers may share in decisions is by being represented at higher management levels. The economic function of an enterprise is one area of decisionmaking. Workers' participation in this area has been considered a matter of particular interest.

A national committee has been working on how to attain the workers' participation in enterprises. The philosophy spreading throughout society today is a belief in the need for direct involvement of people in the institutions and organizations which affect their lives. A main demand is that management's position of command be replaced by a relationship based on cooperation. All important decisions in planning and organization, personnel matters, and changes in the working environment must be made jointly by workers and management. Whether these rights will be laid down in law or regulated through agreements between the two parties will be seen in the near future.

Outlook for the 80's

The expansion of education that has taken place in Sweden in the 1970's makes it obvious that the supply of highly educated health care workers will increase considerably in the near future. Over a ten-year period (1970-1980), the number of physicians will double from 10,500 to 20,500. Correspondingly, the number of dentists and nurses will steadily increase. Neither the resources of the labour market, as mentioned earlier, nor economic resources will permit a similar expansion in all categories of health care workers.

A change in the supply of health care workers will call for a reorganization of the personnel structure in the health service. As a consequence of increases in the number of physicians and nurses, the functions of different categories of health care workers must be changed. The traditional role of physicians and nurses will need to be modified also, in accordance with the supply. It will be necessary to try to define, by analysis of demands, the content in different health care services, to establish guiding principles of the competencies needed, and to develop the new educational system in such a way that health care workers will be trained to fit job profiles of health care services.

In the near future, the personnel costs for health care service may cause problems not only because they account for about 75 percent of the operating costs, but also because reduction of working hours is expected, and this reduction must be met by the employment of more workers. Also the current equalization of wages will increase personnel costs. These circumstances have to be considered in planning of education for and utilization of health care workers.

How to Improve the Utilization of Women in the Health Occupations in Which They are Well Represented

A U.S. Response to the Swedish Experience

Loretta C. Ford, R.N., Ed.D.
Dean, Director of Nursing
University Medical Center School of Nursing
University of Rochester
Rochester, New York

Upon reviewing Johnsson's paper, I was struck with the differences in the political and social philosophies of our respective countries; their relationships to health care and women's roles; and, despite these differences, the similarities of our problems. In this brief response, I will compare the models of health care vis-à-vis the status of women and particularly nurses in health care in the U.S. and present an outlook for the future to utilize the great untapped potential of women for delivering primary health care to the 212 million people of the United States (notice I said health care, not medical care.)

The major noticeable difference between the Swedish and U.S. models of health care is that the U.S. has not enunciated, clearly delineated national health policy from which education of health personnel and health care delivery patterns emanate; nor is there a system or articulation of systems of health care for our nation. Our pluralistic designs with their political, economic and socio-cultural variables have similar problems, however, to those identified by my Swedish colleague. For example, physicians, who are predominately men, control the entry and access gates to episodic, disease-oriented medical care models of practice. Insurance plans require physician control and government plans offer reimbursement for *medical*, not health care.

There is no way to collect your insurance benefits except to declare yourself ill or actually become physically ill. These practice controls, private insurance plans and specialized, categorical government programs, like medicare and medicaid, offer no incentive for people to remain well. Nor do they allow other health professionals—most of whom are women and nurses—to be team partners, or independent providers of health care. For health maintenance, for the identification of actual or potential health problems, for anticipatory guidance and counseling and/or health teaching, for prevention of disease or promotion of health, there is no coverage.

This disease-focused medical care system creates dependencies and deprives people of their rights and opportunities to become responsible for their own health. Consumers of health care must know the options and alternatives so that they can make wise choices about health matters which determine their lives. They must become partners with providers, not passive recipients of brief medical encounters. Changes are occurring, however. Fortunately, concerns about rights of people as patients are extending to women in health care also.

The decade of the 60's was a time of tremendous ferment and change. Emphasis on numbers of health personnel paralleled the Swedish experience with similar results. Though when I reviewed the figures, the ratios seemed comparable, the difference in numbers was phenomenal. For example, the total Swedish labor force, 4.5 million, has the same number of people as we have in our health manpower force. In the U.S., 2.5 million of the 4.5 million health workers are in the occupation of nursing. These workers have preparation ranging from a few weeks to post-doctoral education. Three-fourths of the 4.5 million are women workers. About one million are registered nurses, over 400,000 practical nurses, and about 800,000 are aides and orderlies, a predominately female force. All the sex role issues raised by Johnsson exist here in the U.S. In some ways, Sweden seems more advanced in addressing the needs of women. The provisions for child care, the centralized annual data collection to determine the numbers of kinds of health workers required, the cooperative efforts for counseling, recruiting, training, retaining and offering continuing education and career mobility offer tempting designs and patterns we could emulate.

However, our differing political philosophies and social structures make one wonder if some of the efforts at national planning in Sweden are congruent with our particular brand of democracy which guards jealously, individual rights and confidentiality. Despite the centralized planning for all other health workers, it appeared to me that Swedish physicians are not exposed to the same controls and that other health workers do not have the same educational opportunities that physicians enjoy, particularly at the university level. Ms. Johnsson has indicated that the first university school of nursing will be opened next year. It will be interesting to observe the changes that will be wrought by the introduction of a new educational pattern in nursing.

In the U.S. there is a definite trend for nurses to be educated in institutions of higher education, rather than hospital diploma schools. Twenty years ago, 84 percent of our registered nurse students were enrolled in these schools. Today the enrollment stands at 26 percent, with 35 percent in Associate degree programs and 39 percent enrolled in baccalaureate programs in colleges and universities. Nurses with master's and doctoral degrees have also increased appreciably. Graduate programs in nursing focus on theory construction and nursing science, advanced clinical practice and specialities in nursing. Scientific inquiry and attendant methodologies in preparation for leadership roles in teaching, clinical practice, research, consultation and administration are integral parts of most graduate programs.

66 Testing out new roles for nurses which expanded the scope of nursing practiced gained prominence in the mid-sixties. In 1965, the pediatric nurse practitioner (PNP) model of nursing practice was developed to provide comprehensive well child services and care of acutely and chronically ill children in ambulatory settings. Well qualified nurses expanded their care role, but the nature of nursing was not altered. It retained its basic value to provide care and comfort, guidance, counseling and health teaching.[1] Contrary to some interpretations, this nurse practitioner was not developed as a physician's assistant or just because there were *shortages* of physicians. Shortages of medical manpower, however, did provide the opportunity to test out new roles. The intent of the PNP project was to integrate into graduate and undergraduate nursing education curriculums the content and processes of the nurse practitioner model at the appropriate level of learning.

Since the first nurse practitioner program began approximately 100 others have been started and about 5,000 nurses trained for speciality and generalized services for care of people of all ages. Today, many collegiate programs are beginning to integrate into their curriculums the content and processes generated by the nurse practitioner movement. However, we still do not have enough nurses trained to provide primary care. We also find ourselves with a potential oversupply of nurses prepared at the lower educational levels and severe shortages of clinical specialists, researchers, teachers, administrators for service agencies, education, government and organizational work. Emphasis on the *quality*, rather than quantity of health personnel is now needed. Because, like Sweden, we in the U.S. are wondering how much further we can extend our economic and human resources for health care. Currently we are spending over 100 billion dollars or over 10 percent of the gross national product for health purposes. The U.S. has always given top priority to care of the sick—a very costly priority. Commitment, concerns and allocation of resources for maintaining health are sorely lacking. Some of you will recall Martha Roger's admonition: "Any society which concentrates its resources on care of the sick will never be a healthy society." But women—particularly nurses—will have to take a more active and long term role in emphasizing *health* care. Fortunately there is a definite trend for nurses to remain in the health work force. This trend became noticeable in the late sixties and has been attributed primarily to the rising economic status and professionalization of nurses. Economic and general welfare concerns are also apparent.

Unionization of non-professional workers, particularly in hospitals has been on the increase. Some nurses have joined these industrial-type organizations. Others have chosen to join the professional nursing association (The American Nurses' Association—A.N.A.) which has offered collective bargaining services for the past 28 years. This nurses' organization declares itself a multi-purpose organization for all its registered nurse membership. It functions both as a labor organization and professional activity. Currently under discussion within the organization is the separation of the economic and general welfare program so that the professional and managerial activities of members can be accommodated. While the A.N.A. has been traditionally concerned with the welfare of nurses, it also has shown considerable strength in establishing standards for education and practice, in the certification of practitioners, and in promoting quality assurance. It has influentially impacted upon legislation for Federal funding for education and practice.

Federal monies for nursing education has been the main source of support for leadership and post-graduate training in continuing education in this country. The precariousness of this financial aid has serious implications for long range, interdisciplinary planning for institutions of higher education. These institutions have carried the burden of advanced training without assurances from year to year of ongoing funding. But just preparing nurses to practice does not guarantee that the health care delivery system will use them appropriately. The pluralistic nature of our system makes it difficult to compare the power of nurses in practice arenas in the U.S. and Sweden, partly because we have a non-system of free enterprise in health care delivery. The primacy of medicine superimposes controls upon all other health professionals.

Some organizational structures of hospital and health agencies also pose difficulties for nurses in practice. Some of the new roles created for nurses in the sixties as practitioners and clinicians cannot survive to contribute vitally to the care of people and the health of this nation, if nurses—and women—cannot gain control over their practice, education and research. Currently, in New York State, a major conflict brews over the control of the practice of nurse practitioners and clinicians. Some physicians believe these nurses should be licensed as physician's associates (equivalent to physician's assistants) and controlled by medicine. Nurses vehemently oppose this. They want to be licensed under their own Nurse Practice Acts; they do not consider themselves physician's assistants or physician extenders. (It is a travesty in this country, in this day

and age, that a major government study on nurse practitioners is labelled a study of physician extenders.) Why should nurses extend the disease model of practice? Our mission, well enunciated by Schlotfeldt, is "to help people attain, retain, and regain health."[2] We are accountable to the people we serve; not to physicians. In the interest of care to people, our roles can be complementary, not competitive.

Johnsson's paper reveals that Swedish nurses have great autonomy, especially in some practice areas. Certainly the Swedish models of midwifery and child care practice deserve high praise, and the resultant low infant mortality rate demonstrates that success. However, the status of nurses as decisionmakers in the system hierarchies is less clear. For example, the career mobility for nurses was explained as "going up as far as entering medicine." That makes the medical profession, a predominantly male group, the pinnacle of all health professions. Educated nurses in the U.S. do not consider this either as advancement or vertical career mobility. To us, if a nurse enters medicine it is lateral transferance to another profession. Until there are more common cores of learning for all professionals, so arranged to allow each professional group to retain its identity but also be integrated, there will be little such exchange. Practice patterns and issues in both countries are alike. The studies and their findings on the utilization of nurses, staffing patterns, roles, and distribution in Sweden are very similar to the U.S. experience.

However, emphasis on research into clinical practice and quality assurance are very evident in our country in systems of care and education. Nursing audits, rating scales to measure patient functionality and organizational efforts to develop criterion measures for structure, process and outcome are all very much a part of the American nursing scene. Research into clinical practice problems which address the nurse-patient interaction and focus on outcome measures as determined by the health status of the patient. the family and community is recognized as a developing field in nursing. All university and many collegiate schools of nursing enumerate a goal of scientific inquiry for students and faculty. Production of sophisticated studies to extend the body of knowledge about man in health and illness is still relatively low. At the University of Rochester School of Nursing, recruitment of basic students focuses on attracting scholarly, career-minded students who wish to learn *how to improve practice* not merely to learn how to practice.

Outlook for the 80's: The major problems for the future of women in the health care system and for this country itself are related to: 1) the enunciation of a rational, national policy for health, 2) the need for new conceptualizations about health, and 3) the recognition and wise utilization of the potential of women—particularly professional nurses in health care delivery.

Enunciation of a Health Policy: Hopefully, there will be a national commitment to a health policy which will help guide the efforts of educational institutions in the preparation of *all* health manpower and give direction to the organization of health care services. Current Federal legislation known as the National Health Planning and Resources Act should foster regional planning, but conceptual frames for health care must be developed. If a national policy for health addresses only the *medical* and episodic care needs, the policy will be seriously deficient in meeting the health needs of people and create an economic and social disaster. Both Sweden and England have had a quarter of a century of experience. I would hope we could learn from history without repeating it. Certainly new ways to view health care are in order.

New Conceptualizations About Health: The social, cultural and economic values of a healthy population have never been calculated. Health has been conceptualized very narrowly in the past, majorily as absence of disease. In the sixtie's, health emerged as a basic right. Now, health ought to be viewed as a mechanism for social change and an important component of our national human resources, to be valued and conserved. Positive outcomes of promotion of health, the joys of wellness, the prevention of accidents, disabilities and disease deserve as much, if not greater, attention as care of the ill. We, as providers, must give health care rights back to the people. We, as providers; nurses, physicians and others; have taken responsibility for health care of our people upon our shoulders. Their health is their responsibility, not ours. How they live every day determines in large part their capability and copeability for good health. Our responsibility is to help them understand the options and alternatives so they can make wise choices for their own lives and those of their families and communities. To do this, we as a nation must recognize the great untapped potential of women, particularly nurses in at least one speccific health care arena, primary care.

Nurses in Primary Health Care

Delivery of health care to 212 million people in the U.S. will require tremendous emphasis on primary care delivered from ambulatory settings. Kerr White (1974) explains the health needs of most people in this way:

> "the vast majority of transactions between individuals and health professionals are essentially problem-solving encounters that take place in an open system. Most patients initially present an amorphous array of problems, symptoms, and concerns. These have to be articulated, organized, and understood as the basis for a compassionate, scientific, and sensible course of action. Most illnesses, be they acute or chronic, major or minor, reflect open-ended problems of living and dying for which there are few specific cures or definitive answers. Treatment is largely supportive; it almost always involves choices and a measure of ambiguity and uncertainty. Each encounter is part of a continuum that draws upon past experience in order to look to the future. That future is more than the absence of disease: it is the ability of the

individual to function as adequately as possible in an imperfect world, with as little pain and distress as can be managed for him and those around him." [3]

Professional nurses ought to emulate the apothecaries in Britain who in the 1830's rose up and said, "We are a body of men who exist because the wants of society have raised us up.[4] That group of men became the general medical practitioners of the nineteenth century. What I am proposing is that professional nurses become the general *health*, not medical, practitioners of the twentieth and twenty-first centuries. I believe professional nurses, prepared both scientifically and professionally, can help people assess their health strengths, and identify actual and potential health problems. People can be taught to manage their own health resources, and develop appropriate health-seeking behaviors to use the services available, such as those of nutritionists, physicians, social workers, etc. But university and collegiate schools of nursing will not produce nurses who are dependent on or dominated by medical doctors. University educated nurses, most of whom are women, want autonomy and control over their own practice; they also can function successfully and interdependently because they know, are committed to, and indeed are very happy with their own professional and personal roles.

New vistas for women in the health professions are before us. Those new vistas hold great hope for women everywhere in the world.

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How to Improve the Utilization of Nurses and Allied Health and Support Personnel

A U.S. Response to the Swedish Model

Elizabeth Harding, R.N., M.S.
Assistant Professor
School of Nursing
University of California
San Francisco, California

The United States health system would have a lot to gain by incorporating many of the aspects of the Swedish model into our system.

Today, day-care centers, inservice education programs, career ladder upgrading, workers' responsibilities and involvement of workers with management and decisions, are all steps needed to improve the United States health system.

We, as women health workers, can begin to incorporate these advances into our work situation. For example, the majority of women health workers are nurses, dietary and laundry workers. The women most affected by our discussion today are not here.

One of the major problems to increasing the utilization of women health workers in the United States is the consistent and systematic denial of power to women in health work in decisions affecting our work. Therefore, as an effort to incorporate other women health workers into this conference, this speech was written collectively by a group of women health workers.

Although we can learn from the Swedish model, to fully utilize women health workers, basic structural changes in the United States health system are needed.

We must look at the whole structure in order to prevent ourselves from manipulating women workers like players, leaving the system the same and thus not improving the care received by patients.

There are four basic structural changes that must be made in the health care system in the United States before our skills can be fully utilized. By "fully utilized" we mean creating a system which allows women to work at meaningful jobs which develop their creativity and use their potential fully. The changes needed are: 1) the elimination of the profit motive from the health care system; 2) the control by health workers and consumers of decisions regarding the health care system. Seventy percent of health workers are women, so this specifically means inclusion of women health workers in the decisions; 3) the elimination of racism; and 4) elimination of sexism from our society. Although these are certainly broad goals, they represent the root of the problem. Unless we deal with the basic cause, we will have little success in solving the problem. When examined one by one, each problem shows why women health workers are underutilized.

First, the Elimination of the Profit Motive

At the present time, decisions, about health care are frequently based on economic concerns rather than concerns about the best way to deliver such care. There are many examples of economic concerns taking precedence over patient care needs. Prevention of illness is not practiced in this country for many reasons. One primary reason is the potential expense of providing adequate food, housing, safe and meaningful work, and an adequate income. Drug companies and insurance companies make huge profits at the expense of our illnesses.[1] However, the most relevant example to my discussion today is the current development of Health Maintenance Organizations (HMO's). HMO's have intensified the relationship between profit and the utilization of health workers. An HMO is simply an organization, frequently a large corporation, which agrees to provide to the consumer a predetermined group of health services for a set monthly fee.

In an HMO the provider of health care services is paid in advance and will receive a set fee whether the patient uses the services or not. Under such a plan, if the system is not utilized, the provider makes a greater profit. There is a natural incentive, therefore, for providers to save money in two ways: First, to cut back on services or make services hard for patients to obtain; and second, to cut down on staff. There are, for example, work speedups where no replacements are hired for workers who leave. Another economy measure is to employ LVN's instead of RN's and nurse practitioners instead of doctors. The incentive here is not to improve the utilization of health workers but to save money. Which of us is employed is determined by our price, not by our skills. HMO's are a key feature in all congressional national health insurance bills and are seen as a cure for the health care system. Therefore, our future as health workers may be to work in facilities even more understaffed than they presently are and to be forced into situations making us work above our level of competence merely because it is cheaper.

We will not be able to provide adequate patient care under these conditions. HMO's are just one example of the direct effect of the profit motive on our jobs. We cannot improve our working conditions or our performance until the profit motive is eliminated in the health care system.

Next There is the Problem of Decisionmaking Power

Seventy percent of all health workers in the United States are women.[2] Currently and under all national health insurance proposals, these women health workers have no control over the decisions affecting their jobs and the manner in which they use their skills. We care for patients twenty-four hours a day, frequently know best patient needs, yet we have little input into decisions affecting their care. Frequently, patients never benefit from the skills in which we are competent. For example, nurses (that is RN's, LVN's, and nurse aides) do not have time to provide health education to patients. The nursing staff operates like assembly line workers with no relief time from scheduled duties in which they could offer extra help to patients. This lack of control over the structure of our daily work alienates us from our occupations. We must rely on the benevolence of those in control to determine how our skills are implemented and improved. In the past, as most women know, those in control have not proven to be benevolent or understanding.

To increase our control over decisions made in the health system we suggest the following. 1) Workers must be given time during the workday to share their common experiences, to solve problems and to implement changes. 2) Since we are responsible for providing direct care to patients, health workers must continue to struggle to gain control of the decisionmaking bodies which regulate our jobs. 3) Patients are the ones who understand their needs and how to meet them. We need to participate along with consumer's in the democratic management of our institutions.

Our Third Problem is Racism

People of color within the health system have the lowest paying jobs with the least status. They are frequently nurse aides and LVN's while white women are R.N.'s and nurse practitioners. Ninety-seven percent of RN's are white, so women of color work under the direction of white women who may disregard or not fully understand their valuable contributions about patient care. Racism keeps us divided, arguing between ourselves and protecting our own small space instead of joining together to work collectively for all our benefits. We struggle with each other instead of against the structure in which we work.

The majority of us here today are in positions of authority over minority women. It would be of value to all of us to look at ourselves and how we work with these women. We are all part of the problem, having grown up in a racist society. Changes can begin with each of us. We can begin by including the entire staff in decisions about patient care and staffing.

The basis of racial division within the health system is sanctioned by institutional racism. Third World women are counseled into low level jobs. For example, our high schools provide nurse aide training programs. Women of color are counseled into these programs; white women are counseled to enter college preparatory courses. Institutional racism is made worse by other attitudes such as that minority people are not as qualified as whites for their jobs, regardless of their education. Often those women who manage to graduate from our professional schools are psychologically, socially, or professionally isolated on their jobs. Racism serves to keep our sisters of color down. Their jobs are low paid, leaving them with little money to pay for daycare for their children and no money or time to provide schooling for themselves. All their energies are taken up trying to survive, pay the bills, raise their children, and struggle against the racism they face.

The lack of minority women in the licensed health professions greatly affects the health care received by all, but especially by minorities communities. The majority of Third World people have low incomes and therefore, have the highest incidence of illness. They need health services the most. Since the majority of licensed health professionals are white, even for those Third World people who do obtain health care, there is a cultural gap and language barrier between the worker and the patient.

We must not support a society that divides us along racial lines. We have for too long watched our sisters of color suffer from both racism and sexism. In order to improve the utilization of women in the health fields, a strong program to recruit women of color into the licensed health professions must begin in the high schools. Priority must be given to women of color for admission into health schools, for they are the ones most underutilized. A career ladder, as in Sweden, must be established giving women credit for their work experience, and classes provided at times feasible for working women.

And finally, women of all colors need to recognize the strengths we have if we join together and collectively work for change.

The Fourth Problem Needing Change is Sexism

Expectations of what women workers can do, should do, and are capable of doing are determined by sexual stereotypes. The fact that 93 percent of doctors and 80 percent of administrators are men while 98 percent of RN's and 94 percent of nutritionists are women illustrates this stereotyping.[3] Women's work is not valued in the male hierarchy which evaluates jobs in terms of status, salary and power. Although the women's movement has helped to make people aware of society's limitations on women's opportunities, little has concretely changed to alter women's position.

Statistics show that women are underemployed, underpaid and still bear the brunt of housework and

child care. When we talk about increasing the utilization of women as health workers, we cannot separate their jobs in the economic sphere from their roles as housekeepers and mothers. Chase Manhatten Bank has estimated women housekeepers work an average of 99 hours a week.[4] The majority of women health workers have two full-time jobs.

In order to provide women equal access to all types of work, the government must provide the following.

1) Free day-care at all places of employment. Women cannot compete in the current job market if they are responsible for child care at the same time as they are required to be at work. This is a classic double bind for women who want to work or must work yet do not want to leave their children in precarious and changing care situations.
2) Women houseworkers should be paid for their labor. This concept must be supported by our educational, religious and political institutions. This recognizes it as socially useful labor just as a hired housekeeper is a legitimate occupation which earns a salary.
3) The narrow ideas, concepts and prejudices about women's roles and abilities in our society are currently supported by our religious, educational and economic system. For example, the media continually bombards us with the image of women as sex objects, corporations sell their products using women's bodies to entice the buyer. Hospital shows on TV and the movies place the male doctor in the dominant role. He is making all important decisions and is ordering female nurses to help him. Fields in which women predominate take the brunt of these stereotypes. The society must take responsibility to open up the definition of women's roles and to present a liberated view of women's position.
4) Society values technical, objective and scientific facts; values traditionally viewed as male. This must be countered and value placed on those aspects of society that are labeled "feminine" or "women's work". Some of the most positive aspects of women's work are exemplified in the work done by nurses and other patient care givers. Caring for patients, helping patients to manage their daily activities, helping the new mother with her baby, are all very "feminine" activities. All are very positive, creative and necessary. There must be an integration of the positive aspects of feminity into our values. A transformation of people's inner world is not an easy process but can be done if supported by our culture, government and institutions.
5) As women health workers contacting many individuals in patient care settings, we have the opportunity to communicate new images and ideas of women. We see this as a responsibility for all of us whenever the opportunity arises.

In conclusion we do not support the goal of assimilation of women into the current health system but rather to change that system. Our recommendation for policies and programs which would improve the utilization of women in the delivery of health care in the United States are:

1) Health care must be delivered in a system where patient needs and the quality of health workers' lives are the priority, not profit for companies and institutions. This would call for a redistribution of wealth and a socialistic economy and health care system.
2) All health care institutions must be controlled by workers of these institutions and the people who use them. Every person would then be guaranteed quality health care and a meaningful job.
3) Free quality day-care should be provided at all places of employment and houseworkers should be paid for their labor.
4) A strong national program to recruit and retain minority women into health science schools. All should be given the opportunity for education and career advancement.
5) Time be allowed on the job for health care workers to come together to discuss common problems, concerns and solutions as well as to take continuing education classes.

When these above demands are realized women will have gained more than greater access to health career opportunities. We will have a health system that is truly humane to those it serves and to those it employs.

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Approaches to the Organization of Nurses and Allied Health and Support Personnel: The Australian Experience

Australia: Health Issues and Nursing

Mary E. Patten
Federal Secretary
Royal Australian Nursing Federation
Member, Hospitals and Health Services Commission
Melbourne, Australia

Synopsis of Major Geographic and Demographic Characteristics

Australia's land mass is just under one-third of that of North America, about one quarter the size of Africa, and, as a country or political entity, about one-third the size of the USSR. Its population of approximately 14 million people is concentrated in the temperate climate zones of the coastal strip, and further concentrated in the two major cities of Sydney and Melbourne, which, between them, accommodate about one-third of the total population.

In these cities there is growing evidence of problems associated with high density living, while in other parts of the country the problems are those of isolation. Those living in relative isolation in general live in climatic conditions associated either with extreme heat and low rainfall, or with the "wet" and "dry" seasons of the tropical region. Thus, the population is both concentrated and scattered throughout a relatively large country which overall is about two-thirds desert with a significant tropical area, and a relatively small area of less than one-third of the country with a temperate climate.

The trends in population structure are similar to those of other western industrial societies with a decreasing birth-rate and as a result, what might be termed, an aging population. A significant feature has been not only a decline in the birth rate but also "the tendency for a high proportion of fertility to be compressed into ages 20-29 [and] the striking decline in average age at marriage—especially for females An important related aspect of new trends in population growth is the increasing incidence of married women in the work-force, [although] insufficient is known about the chemistry of this trend to indicate whether it is a consequence of early marriage and completion of family building or whether the new pattern of family building has been *initiated* by wives who want to return to the work-force during their thirties." [1]

A final point to be noted in relation to Australia's demographic structure is the change in ethnic characteristics. It has been estimated [2] that there were about one quarter of a million Aboriginal people scattered throughout Australia in 1788, when Captain Cook raised the flag on behalf of Britain. The initial British population, mostly convicts at first, followed by "free" settlers grew slowly to about five million in 1939. Between 1945 and 1950, apart from British immigrants, settlers arrived from Germany, Holland, Yugoslavia, Poland, Italy, and in more recent years, it is probably possible to find people from most other parts of the world living in what was initially intended to be an outpost of the British Empire. Thus, particularly in the last thirty years, the ethnic origins of the population have become more diverse and with this diversity has come an increasing awareness of the indigenous Australian—the Aboriginal—and a challenge to "the tradition of egaltarianism which has been dominant in Australian society for a century [but which is a] narrow tradition, readily applicable to white Anglo-Saxon Protestant males, but intolerant of diversity and eccentricity." [3]

Issues in Health

Issues in Health in recent years have been much the same as those of other industrialized countries, the main "killers" being diseases of the cardiovascular system, cancer and road accidents. Infectious diseases such as diphtheria, poliomyelitis, measles, whooping cough, have been more or less eliminated, and T.B. controlled in most parts of the country. Leprosy control programmes are still an essential part of health care in areas such as the Northern Territory where populations are predominantly of Aboriginal origin, as are programmes which focus on nutrition. In urban areas particularly, nutritional education emphasizes the problems of bad dietary patterns resulting from a high, rather than a low standard of living, where processed and pre-packed foods are the norm. Preventive programmes focussing on the hazards of excessive consumption of alcohol, the hazards of smoking, and education on the effects of excessive use of common pain killers such as aspirin, have gained ground in recent years.

In all these instances, work has been and is being directed at the prevention of specific diseases, and it is probably only in the last ten to fifteen years that the

concept of promotion of health has begun to gain any significant measure of support. Clearly, promotion of health includes prevention of disease, but the concept of health maintenance, even with inevitable episodes of illness is still an emerging concept.

At a recent conference with about sixty participants, each with a slightly different interest in health care, it was interesting that no real agreement was reached on what health is. One reason for this was that those present did not wish to spend excessive time on debating what could become simply a philosophical argument when questions relating to action needed to fill in gaps in the existing health care system had to be sorted out. Yet a fundamental issue kept surfacing and remained unresolved, namely, the articulation between cultural and social definitions of health and illness, and definitions based solely on medical knowledge. It is significant, however, that the conference recognized the need to encourage community participation in the planning and delivery of health care, and supported recent initiatives which have been taken to help maximize decisionmaking powers at the point of delivery of the service. It would appear that the concept of community determination in relation to the method of delivery of health care is gaining support and to the extent that this is so we shall probably see greater possibilities of articulating social and cultural definitions of health with the scientific knowledge of health care workers. In the process, it is possible that separate delivery systems will be established for specific groups and in fact this has occurred recently with the establishment of centres which aim to deal with the specific health needs of women. At the time of writing this process was further emphasized by a grant to the Central Australian Aboriginal Congress to "investigate ways of establishing an alternative community-based health project which could serve as a model for the re-establishment of a healthy way of living for Aborigines in Central Australia." [4]

The intention of such initiatives is not to establish a pluralistic society in the sense of "a society comprising two or more elements or social orders which live side by side, yet without mingling, in one political unit" [5] but rather to "loosen-up" the existing system in such a way that health care delivery becomes an "open" rather than a "closed" system, able to meet diverse needs. Thus, Australia seems to be moving to a system of health care which is suitable for a population of diverse ethnic origins, even though those of us who are concerned with health care may not yet be in a position to identify clearly some of the implications.

Women in Society

The publication *"Women and Society, an Australian Study* [6] referred to above deals with "Women and Society", "Work", "Education", and "Public Life" as the four major sections of the text with an Introduction dealing with "Sex and Inequality", and a Conclusion which looks to "Women and the Future". It is not intended to review the book here, but it is recommended reading for anyone wanting to gain a greater depth of knowledge of women in Australia. It comes as no surprise to many of us to read that: "Australia, is still a man's world, and the situation of twentieth-century women is still one of subservience"; [7] "The great law which presides over the differentiation between male and female occupations . . . is that of pay and prestige". [8] ". . . the existence of teaching and nursing as easy avenues to employment of semi-professional type, for which girls are encouraged to opt, serves to delay the process of diversification." [9] And finally, "when women do succeed in entering politics, their chances of success depend on conforming to male models". [10] It all sounds so familiar but at least it's nice to know that one's feelings on the subject are neither a figment of the imagination, nor isolated to "odd" individuals.

Yet women in Australia have been responsible singly, or in groups, for reforms. In a speech given by the Prime Minister on International Women's Day, 1975, he reminded his audience of "the great Seamstresses' strike of 1882 . . . (which) led not only to an improvement in the working conditions of their own industry, but to a general investigation of the conditions under which both women and men were labouring." [11] The result was the introduction of legislation aimed at protecting workers in general. A similar theme is found in the final chapter of the Encel study, where it is suggested that the growth of feminist consciousness may make a significant contribution to the future shape of Australian society because of its relationship to and implications for the broader question of social diversity. [12]

Women in Australia, then, have been and still are subject to the realities of inequalities of opportunity based in a fact of life which stems from biological realities, but based also in social practice which is neither inevitable, nor unchangeable. In equalizing opportunity for life and living for women it is indeed to be hoped that there will not be a new imbalance created, but rather that we shall see an enrichment of society through recognition of social diversity in all its forms.

Summary 1

The background picture, then, for the functioning of any national association of health workers can be summarized briefly from the above thumbnail sketches. Any such association is working within a framework of a large country with a relatively small population which is widely dispersed and both isolated in rural and outback areas and concentrated in relatively high density urban areas. The health issues are those of similar industrial societies, yet social change and an increasing recognition of the varying ethnic backgrounds of the country's population is being brought to bear on an interpretation of health and what it means within a heterogeneous society. Climatic conditions produce a range of tropical diseases not normally found in a society of predominantly European origin. These fac-

tors, coupled with a concept of health promotion, rather than just disease prevention, add to the problems of articulation between value systems held by groups within the country, and current medical scientific knowledge. In addition there are changes being wrought in the traditional attitudes of women in society, for women are seeking not only equality of opportunity with men, but it would seem that there is a change in family building—patterns being initiated by wives who want to return to the workforce in their early thirties. The very term "quality of life" is being reinterpreted as Australia moves from the dominance of the egalitarianism of the white Anglo-Saxon male Protestant to a society which is somewhere between this monolithic concept and the separatism embodied in the pluralistic concept.

Organization of Health Workers Represented Predominantly by Women

There are two basic alternatives in Australia for the organization of health workers—organization through professional associations which may or may not have a legal standing conferred under the law, such as under a Company Act or organization through the legalistic union structure of the country. In the main, nurses, physiotherapists, social workers, speech therapists have, in the past, chosen to identify with the professional association concept rather than that of unions, and in some cases, the professional associations have reserved the right to apply educational standards for membership, such membership being in many instances an essential criteria for right of practice. However, most of the occupations in which women are well represented, such as physiotherapy, are relatively new occupations, the major exception being nursing, and the remainder of this paper will deal with nursing which is currently striving to maintain and improve its position in the industrial *and* the professional arenas.

The Royal Australian Nursing Federation (RANF)

RANF is the only national association of nurses in Australia and, at national level, it is registered as a union able to represent nurses employed in or in connection with the industry of nursing. The picture is not quite so simple as that, but, suffice it to say that on the whole negotiation of salaries and conditions of employment in Australia is carried out within a legal framework which makes it possible to gain an award or a determination which covers all relevant employees within the jurisdiction, rather than having to develop a contract on an institutional basis. Registration of an organization under the appropriate act, or at least formal recognition, is an essential feature of the right to represent a group of employees. It is relatively easy, too, to "unseat" a union if it does not comply with the requirements of the act, or if its membership sinks below an acceptable level.

The quotation used above about nursing as an "easy avenue of employment of a semi-professional type" sums up very eloquently the disadvantaged situation of a group of health workers comprised mainly of women. Although not substantiated by research, it is our belief that the knowledge and skills of nurses are fully available to the community because nursing is "women's work" and, therefore, should not reach its potential as this might threaten the predominantly male occupation of medicine. The struggle, then, to go further and improve the knowledge, skills, and the utilization of nursing personnel becomes harder than it should be. The one occupation which has a role independent of medical practitioners is social work, and it would seem at present as though social workers, who are predominantly female, find little empathy with either doctors or nurses, and much frustration in relation to attempts of role redefinition.

RANF is working currently on what can be identified initially as two fronts—the professional and the industrial—for, unlike most of the newer occupations, nurses are reluctant nowadays to be represented industrially by multi-purpose or industry-wide unions. Throughout Australia we have a number of males employed as industrial officers, responsible for preparing and arguing claims for improved salaries and conditions of employment. This appears to be a happy working relationship, and certainly one which has been beneficial to nurses. Perhaps this is because these men help us to come to terms with our more traditional attitudes, basically female attitudes which are associated closely to the traditions of nursing, and as such, work with us in changing attitudes to a more balanced perspective.

A more balanced perspective could be defined as one which recognizes both the community needs, and the right of access to the health service on a continuing basis, and also the rights of the workers in that service to wage justice and to conditions of employment comparable with those of other groups of workers in the community. In a declaration and policy statement issued by RANF in July, 1974, it was stated:

> "that the public still takes the services of nurses for granted,
>
> —that the expansion of hospital and community health services has been at the expense of nurses who are the key workers in the health service,
>
> —that the true worth of nurses has never been properly assessed, and
>
> —that unless remedial measures are introduced urgently the hospital and health services are in grave danger of collapsing." [13]

RANF stated its intent to change attitudes and to achieve positive results which would improve standards of service and the lot of nurses.

During the course of subsequent activity, the pressure brought to bear on nurses to join "real" unions increased considerably. "Real" unions are seen by those who apply such pressures to be unions of greater numerical strength comprising a wide range of employees working in the health industry and concerned only with industrial issues. Certainly, some nurses

prefer membership of such organizations while others have determined, either by preference, or through apathy, that no organizational membership is the desirable state. Whatever the motives of "real" unions, RANF believes that their claims are false, and that the absorption into such organizations would disadvantage nursing still further and do nothing to improve the quality of health care. In some ways, then, RANF initiatives, as an organization of health workers, comprising mainly women, could be seen as both rearguard action and a jump into the future; we are fighting the danger of absorption and loss of identity while moving into a situation of strengthening our identity to enable us to function with greater confidence as an equal among equals in the health team. Clearly, the two are closely related but in terms of emphasis, it is
76 the positive drive into the future which is absorbing most of our energies.

The drive into the future has involved us in establishing a national journal to provide a basis of communication, developing, in association with other interested groups, a report on goals in nursing education, increasing industrial action for wage justice and appropriate conditions of employment, recognizing our political power, without alignment to any particular party, and using it to gain nursing involvement in decision-making arenas, and taking steps to reverse a "top-down" approach to policymaking to a communication flow which synthesizes the knowledge and skills of the leadership with those of the rank and file. The drive into the future is involving us in developing better communication at the organizational level with other groups of health care workers with similar interests and greater involvement in the wider issues of health care and in the general union field. In each of these activities, there is a fundamental belief, that while we may be labelled at times as deviant, the response of others will be determined to a large extent by our own definition of ourselves. Therefore, we ourselves must think through who we are, and what we are in relation to others with whom we work, be they other health care workers, clients/paitents, policymakers, or whatever. We cannot lay the total responsibility at the door of others for what we are or what we will become.

In this process of rethinking, it is as useful for nurses to pool their resources in their own organization, just as women have found it helpful to organize as women. However, we shall not survive as an identifiable entity if we do not also reach outside of ourselves, and this is precisely what RANF is attempting to do—strengthen our identity and reach outside. In reaching outside of nursing we are attempting not only to communicate with others of similar interests, but to participate in the wider issues off health. This latter participation is in its early stages at present, and to the extent that wider issues raised in the national journal have drawn only marginal interest, this will probably take time. However, it is significant that individual nurses recognized years ago the inadequacy of the health care system in meeting the needs of populations of diverse ethnic origins and the fact that the disease-oriented health service fell a long way short of being, in fact, a health service. Hence, it is more a case of mobilizing nurses to maximize their potential contribution to and utilization in health care, rather than starting on an entirely new and foreign track. The fact though, that many nurses have been vocal, as individuals, throughout a period of years, about shortcomings in health care, suggests that until medicine "discovers" the problems, the impact is likely to be marginal. Whether such an assertion is linked to female/male relationships is a matter for speculation, although there is a distinct possibility of a significant correlation. What is certain though is that nurses have been underutilized in the sense that their potential leadership in forging change has not been realized. It is our job as an organization, to back the nurse in the work situation. This can be done effectively only to the extent that nurses are involved in the activities of the organization.

One of the problems associated with the involvement of nurses in RANF has been the lack of a career concept in nursing. Most young nurses, particularly in past years, saw nursing as a useful and rewarding occupation prior to marriage, so that a career in nursing was more by accident than by design. This is changing and more married women are returning to nursing, and some are reaching positions of seniority. However, with this change comes also a new set of problems in relation to traditional patterns of work, as many of the married nurses have an involvement with their families which they want to retain. Such problems could open up consideration of many other issues; without examining these issues in depth it can be said that this trend, along with other factors, is causing nursing to take a hard look at the organization of work and the utilization of nursing personnel and RANF is beginning to get involved in such issues which have both industrial and professional implications.

Summary 2

The Royal Australian Nursing Federation is registered as a union and is concerned with industrial and professional issues. The above sketch has not touched explicitly on the interlocking relationships of the industrial and professional, although this interlocking is implicit in much of the text. RANF is seeking to enrich the role of nurses by strengthening the identity of nursing in the health team while, at the same time, reach out to communicate with other health workers with similar interests. RANF has increased its campaign for wage justice for nurses and is attempting to create a communication flow which synthesizes the knowledge and skills of the leadership and the rank and file. Nursing, as an emerging profession suffers many of the disadvantages faced by women in the community at large which makes the striving for industrial and/or professional improvements more difficult.

Conclusion

This paper has attempted to show that the organiza-

tion of any group of workers must be considered within the context of geographic, demographic, social and cultural characteristics of the country. It has referred specifically to these characteristics in Australia as well as to health issues and the organization of nurses as a group of health workers in which women are well represented numerically. It has been suggested that the problems faced by nurses which include problems related to the utilization of the knowledge and skills of nurses are affected by the fact that nursing is traditionally women's work. The acivities of the Royal Australian Nursing Federation have been outlined, and it is hoped that this outline has demonstrated that the process change is complex, as are the issues involved.

The overall philosophy behind this paper can best be summed up in the following statement of Marc Lalonde: "Good health is the bedrock on which social progress is built. A nation of healthy people can do those things that make life worthwhile, and as the level of health increases so does the potential for happiness." [14]

To the extent that nursing, as part of the feminist movement contributes to health, and the enrichment of society through recognition of social diversity in all its forms, so will nurses reach their potential as women and as nurses, and so will health care in Australia be enriched.

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Approaches to the Organization of Nurses and Allied Health and Support Personnel

A U.S. Response to the Australian Experience

Virginia S. Cleland, R.N., Ph.D.
Professor of Nursing
Director of Graduate Studies
Wayne State University

I was very pleased to be asked to respond today to Mary Patten's paper on organization of Australian nurses. I associate Ms. Patten with the report of the conference she chaired in Geneva late in 1973 which was co-sponsored by the International Labor Organization and the World Health Organization. That document titled *Conditions of Work and Life of Nursing Personnel* is a most complete yet concise statement of the principles and concepts involved in the employment of nurses, including the right to organize for the purpose of collective bargaining and the right to strike, if necessary.

When Mary Patten describes the nursing scene in Australia, I readily perceive many similarities with our own position in the U.S.A. The American Nurses Association like the Royal Australian Nursing Federation simultaneously promotes the general welfare of nurses and the standards of professional care which relate to patient services. It is upon these interlocking functions of the professional organization that I will focus my remarks today.

It is impossible to view nursing in any social or cultural context without recognition of the effect of sex role discrimination.

The fact that there is an overwhelming majority of males among physicians and among office holders in the public and private sectors of health system organizations, has had an effect upon the nature and configuration of the health system decisions which, in turn, have supported the subjugation of nurses as individuals and as a profession.

There are similarities between the power relationship which has commonly existed between the positions of husband and wife, between male physician and female nurse, and between health institution administrator and nurse employee. All have been viewed as legitimate power relationships. When French and Raven [1] first published their typology of the "Bases of Social Power" in 1959, they wrote, "In most cultures, there are certain areas of behavior in which a person of one sex is granted the right to prescribe behavior for the other sex." [2] (Raven has refrained from using that illustration in his more recent writings.) Notice that the basis of legitimate power is the recipient's acceptance of a role relationship imposed by the influencing agent. The unique characteristic is that the influencing agent is perceived as having the right to exert influence. Legitimate power, by definition, reflects a relationship between offices or positions rather than between persons. The dependence of wives, nurses, and employees is changing. While much still remains, these dependency roles are probably less supported by the normative beliefs of persons outside the relationship than in any previous time in history.

As women increasingly repudiate marital relationships which involve total economic and social dependency, nurses too are rejecting physician leadership in those areas of health care wherein the physician has no special expertise. Ethically, the role of the nurse is changing from one characterized by physician and institution loyalty to that of patient advocate.

Health system changes are difficult to perceive. There is considerable evidence that nurse practitioners with four to six years of preparation can provide primary health services for many of the patients seen in ambulatory care settings. The issue is not whether such nurses can deliver primary health care; the issue is not whether patients will accept these services from a nurse: research findings have repeatedly answered these questions affirmatively. The issue is the physician-gatekeeper in relation to third party payment. The Department of Health, Education, and Welfare has invested vast amounts of tax money in the system of health care with little effort, proportionately, directed toward learning to categorize patients, not by income level, but rather by the nature of their health care needs. Greater emphasis should be directed toward defining the types of health professionals who can most economically and effectively provide needed service. Few believe that this can be accomplished within the framework of the currently existing fee-for-service, insurance-type reimbursement.

Nurses can be expected to turn with increasing frequency to collective bargaining and the power base of labor law to attempt to correct those problems which the health system has been so disinterested in changing. The jurisdictional expansion of the National Labor Relations Act in 1974 to include employees of

private health care institutions will greatly increase the numbers of nurses who can now elect to have the protections offered by that law. The historically conservative attitudes of nurses can be predicted to be influenced by the increasing frequency of the use of collective bargaining by medical residents and interns, college professors, public school teachers, and the most recent work stoppages by physicians.

There are over 815,000 registered nurses, 459,000 licensed practical nurses and 910,000 aides, orderlies, and attendants employed in the health field in the U.S.[3] A juicy plum of two and one-quarter million workers is being plucked by union organizers.

A very recent ruling by the National Labor Relations Board (NLRB) has been made in the case involving Mercy Hospital of Sacramento and the California
80 Nurses Association.[4] The National Board overruled a regional director who had included within a bargaining unit registered nurses, pharmacists, medical laboratory technicians, dieticians and others. The NLRB stated, "We have concluded that registered nurses possess, among themselves, interests evidencing a greater degree of separateness than those possessed by most other professional employees in the health care industry. These distinct interests derive not only from the role and responsibilities of registered nurses, but, also from an impressive history of exclusive representation and collective bargaining." The NLRB did not rule on the question of whether registered nurses can be included in a collective bargaining unit with other health professionals when they have not petitioned to be excluded. While this was a landmark decision for professional nursing, the battle is only partially won until this latter point is clarified.

The composition of the bargaining unit will determine whether an industrial model or a professional model of collective bargaining can be used. The two systems differ by being derived from a different base of power and utilizing different influence processes. I believe the public has a great deal at stake in the choice of model.

The industrial union model is based upon the use of reward power and coercive power. The reward is generally higher salaries paid by the employer in response to the coercive power of a strike threat if the reward offered is not viewed as adequate. Kelman [5] has identified the resultant influence process as that of compliance (to the rules of the institution) which is dependent upon surveillance or direct observation of the worker's performance. This is the basic power mechanism of an industrial-type union:

Threat of Coercive Power
Use of Reward Power
Surveillance of Work Performance
Compliance to Agency Rules

While it is certainly possible for a professional organization to develop contracts which are no different from those written by industrial-type unions, a professional model for collective bargaining can be built upon quite a different power base. The professional nurse is licensed in every State. This affords the nurse legally based "expert" power independent of any authority bestowed by management within the institution. By law, nurses are held individually accountable. To be accountable for the nature and quality of one's practice within an institution, there must be some system of shared governance. Such systems of shared governance are common within medical staff organizations of hospitals and within faculty organizations of colleges and universities. The essential requirement is that the professional unit must have legislative authority for policies of nursing care while administration retains executive authority for implementation through control of resources. Because of the nature of this legislative authority I believe, it is essential that registered nurses be organized into self-contained bargaining units.

What is the probable difference in the social influence process involved in collective bargaining based upon a professional model? From Kelman's theoretical framework, one could hypothesize that the influence occurs through identification. The State nurses association can assist the bargaining unit to develop a contract which makes certain decisionmaking influence available to registered nurses which they have been unable to obtain for themselves without such organizational assistance. Then, through the process of identification, the individual strives to assume more of that organization's espoused values in order to maintain and support that desired relationship. The satisfaction derived from identification is through the act of conforming to certain types of behavior which are viewed as goal oriented. The end result from the employer's view is that the nurse, by becoming self-motivated to achieve the professional nursing goals of the institution, becomes more self-directing and requires minimal supervision and direction.

If the nurses are assisted to use a professional model for collective bargaining what could the public expect as some end results? First, I believe, many of the contract costs which today are assigned to increased salaries and broader fringe benefits on an across-the-board basis could be diverted, through a system of peer review, to those employees making the greatest contribution to the nursing goals. Nursing has passed through three decades in which literally any registered nurse could obtain employment. At issue was not the nurse's competence, but only the matter of a current license and a willingness to be employed. To develop and maintain the confidence of the public, nursing must be permitted to assume responsibility for the quality of its services. Traditionally, unions have avoided, as being internally destructive, any situation wherein one worker is judged more meritorious than another.

Second, under a professional model of collective bargaining there is a direct relationship to the resources

of the professional nursing organization. The most significant of these are probably the new system of advanced certification in clinical practice and the vast new system of continuing education being developed in every State. It is only a matter of time until evidence of continuing education will be mandatory for renewal of the license to practice nursing.

Third, the nurse has a legal right to negotiate working conditions which effect the quality of care. In Michigan we have found, time and time again, that nurses organize because they are so frustrated about the conditions of care in the institution in which they are employed. The professional model with its mechanisms for shared governance through nursing care committees provides a means for resolving problems short of the grievance procedure. Negotiations for conditions of care become an ongoing process and not simply a series of problems to be resolved before contract signing.

Although the women's movement has resulted in significant improvements for women, the employment structure has remained essentially unchanging for nurses. To end sex discrimination is essential, but it is not enough. The difficult task will be to alter the health system sufficiently to make possible the full contribution of nurses and nursing. Collective organization offers that means.

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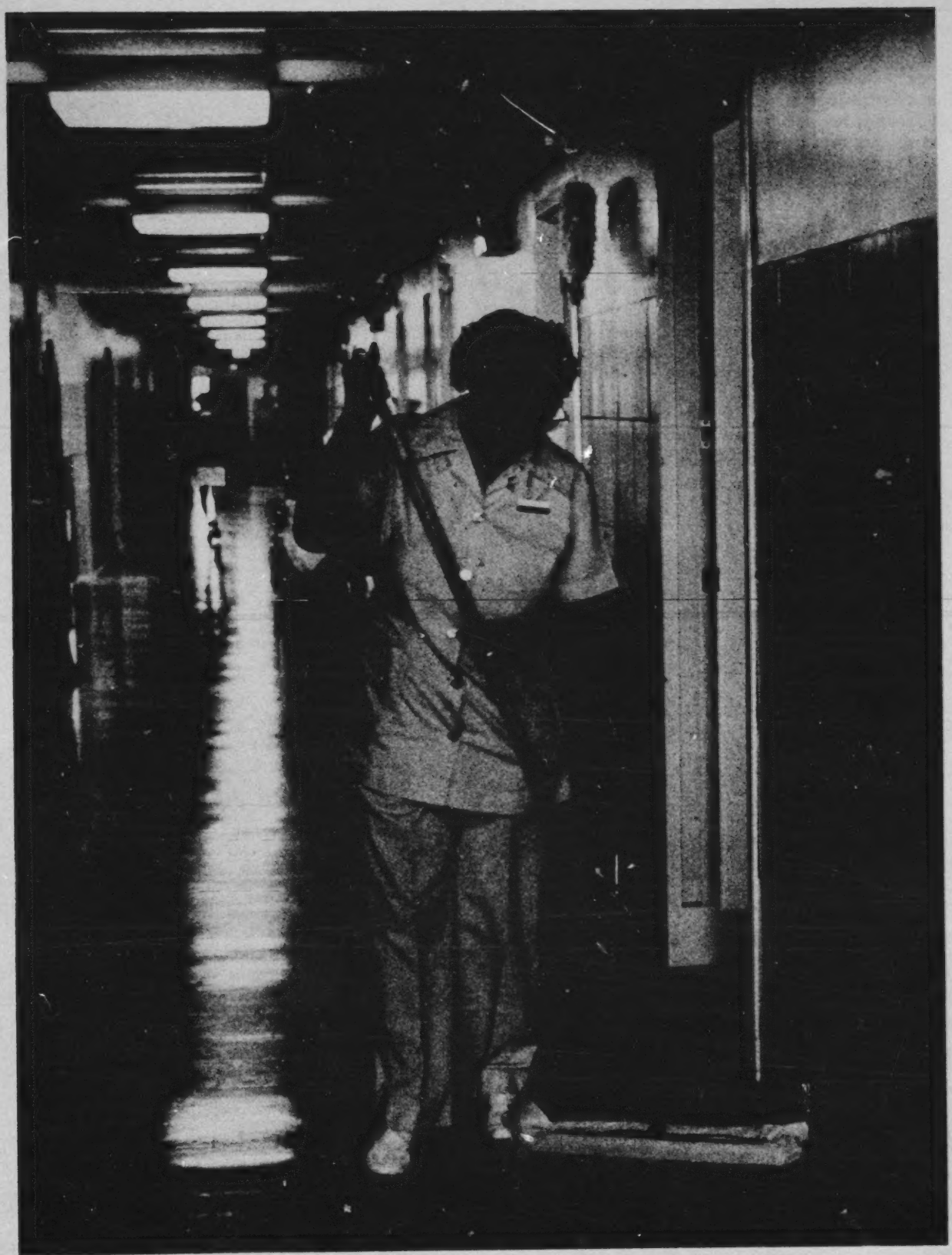

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Innovations in the Utilization of Nurses, Allied Health and Support Personnel: A Look at Colombia

Women and Their Role in Innovative Health Programs

Maricel Manfredi, R.N., M.S.
Director, Department of Nursing
University of Valle
Cali, Colombia

When I was invited by you to write a paper in which I would explain the participation of women in the development of systems offering health services in Colombia, I did not hesitate to accept such an invitation. I felt overwhelmed by the fact that I was collaborating with a group of renowned research women of high national and international position with whom I could not compete, since I find myself only promoting research within the field of nursing in the Universidad del Valle. I would say that I did not hesitate in accepting such an invitation because I considered it important to have the opportunity to emphasize the fundamental fact that in many service programs in my country women have participated widely in the developmental stages.

It is, therefore, the proper moment in this year of the female to emphasize the deserving and quiet labor of many of our Colombian women.

Women in Colombia and Their Role in Society

Colombia has 21,070,115 inhabitants of which 50.7 percent are women. The most numerous group is that of women between the ages of 15 and 49 years which represents 22 percent of the total. Little more than half are between the ages of 15 and 29 years and three-quarters of them are less than 40 years of age. In other words, Colombia has a great number of women in a productive age.

Of the women between 15 and 54 years of age 22.7 percent have gone to school and 61.2 percent of the women in this age range have had some studies in primary school, 15.1 percent have had some sort of secondary school and only one percent of our women have had the privilege of studying at a high school or university. In recent years a great effort has been made in the educational field and the scholarships of young women have increased. Teaching is starting to become diversified and it is in this manner that preparation is offered women in vocational fields; for example, nurse's aides and helpers. Women show better skills in those areas they have already been working in. Yet the fact that a great number of women only attend primary school means that their most frequent occupations are that of service workers, artisans, saleswomen and clerks.

> "The traditional role of women in Colombia has been largely confined to their home functions as mothers, wives and the prevalence of their biological functions which are not yet completely under their control, and that is why their creative opinions in the social, economic and educational fields have been very limited to date, as limited as their ability has been to make decisions in the home and in the concomitant areas of responsibility." [1]

Authority within the family circle has been clearly defined, and in decisionmaking their age, sex and schooling have been a definite influence; women have been subordinated to men and children. This subordination of women to men has been seen in many aspects of family life, not only in the wife-husband relationship, but also in the fact that the son has priority over the daughter insofar as as education is concerned.

In the last few decades industrial technological advances have had great repercussions on urban family sociology. In the economic area, class or lineage privileges are no longer as important as the efficiency or capacity factors. Thus, function determines status. "The greater influence of roles in the industrial age begins to take the women out of a restricted home life and by means of formal education, in which certain class factors are compromised, she has her entry into the job market. Even though feminist groups have entered the labor market, the economic responsibility factor considering authority as a basis has not been sufficient in this transition stage to strengthen the feminine ego in decisionmaking, its consequent responsibility, and the hierarchization and obtention of privileges. There is only a bare insinuation of a beginning of manifest participation of women in the authority complex." [2]

Even though up to now an appreciable number of women have obtained authority by occupying public jobs which were previously the exclusive province of men, their capacity has demonstrated to our statisticians the need in Colombia to eliminate all sex discrimina-

tion. This is the reason why Decree 2820 of 1974, the new statute on women's rights, was approved.

We now have the great task in our country of giving impetus to the development of a greater number of feminine leaders who shall arouse feminine consciousness, so that these laws are obeyed.

Role of Women in the Health Field

Women in Colombia have actively participated in the health area. Their status and, therefore, their role has changed considerably as they are given the opportunity to prepare for the functions that they should carry out. In the area of medicine their initiation into this profession is rather recent, going back only 30 years. As compared to males, not many women have studied in this field. Even though there are many outstanding women in the medical profession in the field of general practice, research and education, the total identification of medicine with males with which they work may be one of the reasons that has prevented them from excelling more activitely as feminine leaders in the field of medicine.

Nursing, an eminently feminine profession, has been considered as having little prestige until very recently. This has led to Colombia's having a rather small number of professional nurses which has not been increasing at the expected rate. The reason for this low prestige is very closely related to factors of social structure. The work of a woman outside the home was not well regarded in our traditional society. Another factor could be the low monetary remuneration, due to its being considered a profession with a greater number of manual than intellectual skills.

Recent studies show that nursing is acquiring greater prestige. In a study carried out by Bertrand and M. Cklin in the city of Cali, Colombia, on the prestige of health occupations, they found that the nurse occupies the second place of importance among the health professions, while the dentist occupies a lower place. The authors of this study believe that this is due to the low number of professional nurses which Colombia has and to the fact that they carry out an administrative function, which causes them to have great prestige among the public to whom they render their services, as, for instance, administrators of a health clinic, etc. Nevertheless, other prestige factors must be considered:

a. The change in the role of women in our society which has permitted more women to enter a university;

b. The present importance of those professions which are more closely related to the needs of human beings, the better remuneration which the nurses are demanding for their services; and

c. Progress in nursing education which has led to nursing being considered a separate profession and not as dependent on a school of medicine.

The scant number of nurses previously mentioned has caused the development of different types of auxiliary personnel in Colombia to help in the health care of our people. Since these auxiliary personnel are prepared on a vocational level, their role as functionaries of direct medical and nursing care places them in a very important position within the system of rendering health services. In a study conducted by three nurses, Benavides, Andrade and Gil, on "Some Opinions and Attitudes of the Community Regarding the Delegation of Medical Activities in the Infant-Maternal Area," a preference is shown for feminine auxiliary personnel, since the patients show more confidence in expressing their doubts or fears to women. This is intimately connected with traditional aspects of bashfulness which are very deeply rooted in the feminine populace of our country. The use of female aides also permits the establishment of good interpersonal relationships, since these personnel are more cognizant of the customs and values of the patients.

Women and the Innovative Programs of Rendering Services

Next I shall present three programs of an experimental nature which are presently being developed in the Health Division of the Universidad del Valle, showing female participation on different levels. These programs have had not only local repercussions in the city of Cali, which is where the University is located, but on regional, national and international levels as well. They are:

Study of Infants' Maternal Care and Utilization of Health Services in Relation to the Activities of the Health Aide,

Primops Program, and

Program of Ambulatory Nursing.

Study of Infants' Maternal Care and Utilization of Health Services in Relation to the Activities of the Health Aide

In Colombia a great part of the population lives in rural areas where health services are scanty or simply nonexistent. The study on human resources demonstrated that only 34% of the population was able to obtain medical attention; there were 4.3 doctors and 0.64 nurses per 10,000 inhabitants; and there were only 3,500 certified auxiliary nurses and most of them are concentrated in the large cities.

The problem increases in populations geographically, economically and culturally isolated, which limits transportation and/or communication, not permitting the delivery of professional assistance. In search of solutions to this problem in 1964, the Colombian government started the formation of a rural health aide. The aide is defined as a voluntary resident in a community or area who knows how to read and write, who is accepted by the community where she resides permanently, who has time available to work in collaboration with the health unit and who receives special training in the work she is to accomplish on a rural level. Her functions are:

Promotion of the services of health care, especially on the infant-maternal program; promotion of sanitary

measures; first aid; application of treatment formulated by the doctors; and control of alarm signals in her area for women who are pregnant and in puerperium in order to send them to the health unit at the proper time.[3]

Even though the government was convinced of the effectiveness of the aide, no studies to confirm such a concept existed. The Nursing Department of the Universidad del Valle proposed to the Colombian government and to the OPS to carry out a study which would show the effectiveness of the aide in the improvement of knowledge, practices and attitudes in the infant-maternal area, would raise the health level of the population and would determine the cost-effect relationship of the programmed instruction of the training program.

The area selected was the Valley of Sibundoy which is located to the south of Colombia in the Administration of the Putumayo. Its altitude is 2,100 and 2,200 meters above sea level and a land area of 9,000 meters. The total population is 15,025 inhabitants, distributed as follows: mixed-breed and whites, qualified as "whites" which constitute 60 percent of the population, and indigenous Kansa and Ingas, which constitute the other 40 percent. For the purposes of the study, the white population was selected, since it is a more representative sample of the Colombian population. 49.8 percent of that population is made up of children under 15 years of age. It has a low index of illiteracy, 18 percent of the total population, and the average schooling is three years of primary school. This is due to the fact that this is a missionary area and the Catholic church has established 21 primary education schools. There is aqueduct service but the water is untreated. This place was selected for the availability of communication facilities and for its proximity to villages.

The study began with a survey of the community in order to determine certain basic information as to socio-demographic, morbidity-mortality data, maternal care of infants and attitudes. Once this survey was carried out we proceeded with the training of the aides, utilizing programmed instruction as a basis. At present, the aide is working in the community.

The results have already been obtained on the cost effectiveness of the programmed instruction in the training of the rural aides. Some preliminary results on the changes in attitudes, knowledge and infants' maternal care found in the researched population after the first year of work with the aide have also become available.

As far as the use of programmed instruction, the results showed that the method of programmed instruction used in the training of the health aides is more effective than the traditional programs ($0.1 < p < 0.05$).

The method of programmed instruction is less costly than the traditional one when the programmed instruction units already described are used.[4] Accordingly, the Public Health Ministry of Colombia has initiated the training of aides with this method.

Regarding the changes of infants' maternal care and attitudes, the data collected before the aide started her work was compared with the data obtained after one year and two months of work. The results were as follows:

Insofar as knowledge of the methods of family planning is concerned, it was found that, although the number of women who knew the methods had not increased significantly, the types of methods used by them were more modern, for instance, the IUD and the "pill". The sources of information on the mother-child programs changed significantly, based on radio programs and information passed on by midwives to the other members of the health team, including the aide.

Regarding attitudes toward family planning, it was found that the number of children desired changed significantly ($P < 0.01$).

Seventy-eight percent said that they wanted assistance in a program of family planning, showing greater interest than the previous year ($P < 0.05$).

It was also found that a greater number of births are being attended to in the health-care institutions.[5]

It is expected that further changes will be found in the maternal-infant practices after the second year of work by the aides, since changes have been found in the knowledge and attitudes after the first year.

Program of Investigation in Models of Rendering Health Services

The experiments were carried out by the Health Division in a small city of 7,000 inhabitants (Candelaria), where a program of services was developed in the infant-maternal area utilizing the delegation of functions to nursing auxiliary personnel. The following results were obtained.

A decrease of the general infant and pre-school mortality rate;

A decrease of the newborn rate from 60.2 per thousand in 1962 to 41 per thousand in 1971;

A decrease of malnutrition in the pre-school child from 40 percent in 1964 to 22 percent in 1971 and eradication of the severe forms of Kwashiorkor and marasmus; and an increase of the levels of coverage of the different programs in approximately 80 percent, insofar as maternal attention is concerned, attention to the child and attention to the couple (family planning programs and sanitary programs).[6]

Taking into consideration these experiments, the Health Division and the Health District of Cali are developing the design, implementation, operation, evaluation and documentation of a model of rendering integral health care in a marginal area of the city of Cali of 100,000 inhabitants. This may be duplicated in other parts of the country. It purports to improve the health conditions and the life quality of the community. It is also hoped that the program will demonstrate the rational use of different levels of health personnel as well as of persons in the community in the delivery of the health services. The model is organized in such a manner that it incorporates itself

into the system of rendering services already established by the Colombian government.

Once the model has been tested, it is hoped that it will demonstrate the viability of integrating the teaching system and the system of rendering health services with an end to unifying efforts in the study of the community health problems and of their possible solutions, thus encouraging the formation of a health team which is in keeping with the realities of the community and the characteristics of the health system.

Health Principles on Which the Model is Based

The model is based on the following principles:

1. The solution to the health problem is directly related to the degree of active community participation and to the degree of integration which may be reached between it and the health sector.

2. The solution to the health problem is directly related to the degree of coordination and integration which is attained among medical care institutions.

3. The solution to the health problem is directly related to the degree of regionalization which may be reached. (Regionalization in our country means the stratified organization of the medical care levels which ranges from home care to specialized hospital via the local health department and the health center in a predetermined area.)

4. The solution to the health problem is directly related to the integral care given the patient (promotion, prevention and healing).

5. The solution to the health problem is directly related to systematic low-cost care.

6. The solution to the health problem is directly related to the realignment of medical care activities within the health team.

7. The solution to the health problem is directly related to health systems with high population coverage, dedicating their greatest effort to high-risk groups.

8. The solution to the health problem is directly related to the availability of an evaluation system which measures the efficiency, effectiveness and quality of care being delivered to the community, and which allows ongoing adjustments to the proposed health plan.[7]

Operational Methodology

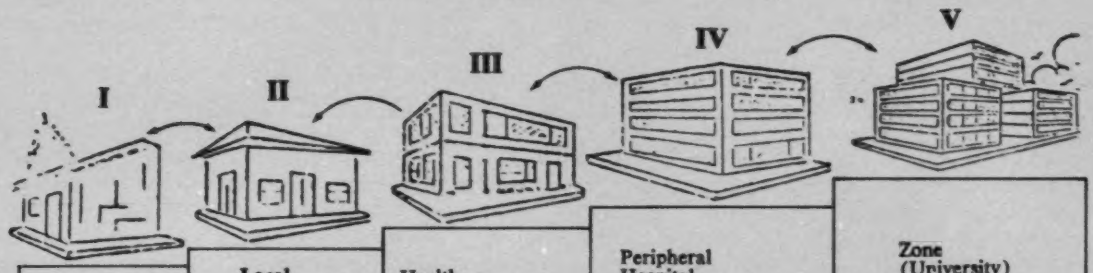
In its first stage the model provides coverage to persons with the greatest risk, that is, the mother and the child. In a second stage, it may cover the whole family. In 1973 the model was put into practice, to render health care to the community adjacent to the city of Cali. The program was organized as follows:

First Level—The Home:

It is defined as the priority work unit (P.W.U.) which is composed of families having children less than five years of age, pregnant females, or those of reproductive age. Each group of 2,500 inhabitants is served by a basic health team of two or three midwives, one nursing auxiliary and one aide who visits them at home. The functions which they perform are as follows:

1. Control of growth and development and of the nutritional status of the child;
2. Immunizations;
3. Maternal education in child care, hygiene, sanita-

LEVELS OF CARE



Level:	Home	Local Health Dept.	Health Center	Peripheral Hospital (Local b)	Zone (University) Hospital
Sector	U.T.P.	Town Quarter	Health Department	Programmed Area	Zone
Covered Population	Families With Children Below 5 Years of Age	10,000-20,000 Inhabitants	100,000 Inhabitants	100,000-150,000 Inhabitants	4 Million
Personnel	Aide Auxiliary Midwife	Auxiliary Aide	Doctor, Dentist, Nurse, Technicians, Nursing Auxiliaries	G. P., Dentist, Nurse, Nursing Auxiliary, Technicians, Administrators	Specialists and Superspecialists

tion and utilization of the services which the program renders;

4. Notation of vital statistics;
5. Detection of women who may be suspected of being pregnant; and
6. Notation of morbidity.

Home visits of the nursing auxiliary in order to:

1. Carry out prenatal care;
2. Surveillance of births attended by midwives in the home;
3. Postnatal care;
4. Epidemiologic data collection; and
5. Care of children with special problems (severe malnutrition, etc.)
6. Home visit of the midwife for births.

Second Level—Local Health Department:

The local health department is located in a quarter of a town [barrio]. A quarter of a town is an administrative political division which subdivides the city and which has an area of 15,000 to 20,000 inhabitants; the town quarter has a local health department managed by a nursing auxiliary under the supervision of a registered nurse. The activities of the nursing auxiliary are as follows:

1. Care of sick children in cases of diarrhea and/or Grade I dehydration, catarrhal and febrile states, mild piodermitis, varicella, chicken pox and parasitism;
2. Care of pregnant women with mild pregnancy complications;
3. Injections and care of the sick;
4. Referral of sick child or adult who needs to pass to a higher level;
5. Clinical education and surveillance of couples in the family planning program;
6. Notation of health activities and vital facts;
7. Vaginal smears; and
8. First aid: sutures, foreign bodies, etc.

Third Level—Health Center:

The health center covers a populatoin of 100,000 inhabitants. On this level there are nurses, doctors, dentists and technical personnel. There is also a pharmacy, clinical laboratory and ambulance transportation system. To this center come the patients who are referred by the auxiliary. It provides all kinds of ambulatory services rendered by professional personnel except hospitalization.

Fourth Level—Peripheral Hospital:

It covers a region of 250,000 inhabitants, more or less, and provides ambulatory hospitalization services with fast turnover, as well as post-surgical care in the home.

Fifth Level—Zonal

At the zonal level, a university hospital covering a population of 4,000,000 persons provides all the basic and specialized services.

The model also includes an evaluation tool which allows for efficiency measures. In other words, how adequate is the utilization of the resources and how effective are the benefits obtained by the community?

Administration of the Model

The model has an administrative organization made up of a director and a co-director. The director is a professor of Social Medicine in the Universidad del Valle and the co-director is named by the Local Health Secretary. In addition, it has advisory and technical committees and the units for human resources, evaluation, investigation and administration.

The Human Resources Unit is directed by a nurse. Four professional nurses work in this unit. The functions of this group are in the fields of recruitment, selection, training, supervision and personnel evaluation models, which will be applied to the different working groups within the proposed service model. See the Nurse's Placement diagram.

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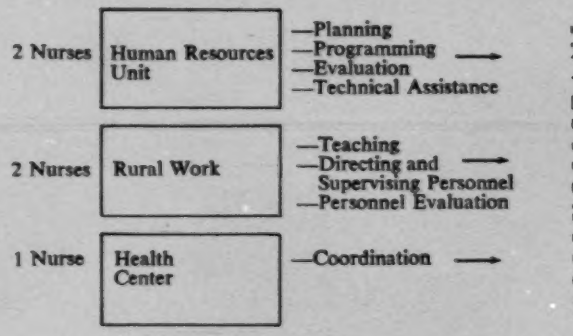
Diagram of the Placement of Nurses in the Investigation Program in the Models of Rendering Health Services



From 1972 until the end of 1973 service units were programmed and developed in terms of activities and tasks for each of the members of the team, and we proceeded to train the personnel already working in the field. Ninty-three persons have been trained: nine auxiliaries, 54 aides and 30 midwives who are rendering service in an area of 30,000 inhabitants.

The Nurse in Ambulatory Care: An experience

In the year 1973, conscious of the necessity of preparing the nurse better in adult care, we started in the Nursing Department of the Universidad del Valle to program a course on an experimental basis with the purpose of expanding the role of the nurse in the adult area by introducing some knowledge, techniques and abilities which would permit them to make a better evaluation of the patient as well as making some decisions insofar as treatment is concerned.

We thought of focusing the course towards the ambulatory area due to the necessities which exist in our country for offering and increasing the coverage of ambulatory care for the adult patient. The studies realized in Colombia show that a reduced number of

the population enjoys medical care and since one adult support seven other persons, his protection during the productive years is obviously a priority.

At the outset, advice was solicited from a "nurse practitioner" from the Rockefeller Foundation, who, with one of our professors and a group of doctors of the Health Division, planned and developed an experimental course which prepared a group of nurses to offer a minimal amount of care in the patient's ambulatory treatment. Minimal care was defined as the care given physically capable or partially incapacitated patients, placed in hospitalization units for short stays, as outpatients or in home care.

To offer this minimal care the nurse was prepared to: evaluate the health status of the patients by means of the clinical history; diagnose and treat certain selected common entities; and observe patients with certain chronic illnesses.

This course was divided into two parts. In the first part the student received information on the health situation of the adult, national programs planned to resolve it and their implications in the nurse's role.

The concepts and techniques of the clinical history were introduced accompanied by the necessary elements of anatomy, physiology and symptomology. Furthermore, emphasis was placed on the utilization of the basic training of the nurse and on the identification of the socioeconomic and cultural problems of the patient, which might help her to participate fully in the evaluation of the patient's health status.

The second part encompassed the diagnosis, treatment and follow-up of the patients with common illnesses easy to manage and the management of patients with selected chronic illnesses.

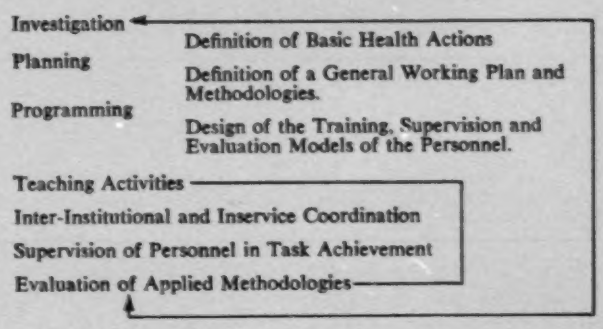
The choice of these entities was made based on the study of an adult out-patient clinic and on the opinions of the different specialists.[a]

The first course in this project was carried out from August to December of last year. Eight nurses participated, four of whom work in the health center of the area surrounding Cali, and two in the rural health centers. Two professors from our university also participated.

The course was held on Fridays and Saturdays, when the theoretical parts were presented in lectures and some practical exercises were carried out. In addition, the participants had to dedicate at least 4 hours of their work to the care of patients. Each of the participants worked with a medical tutor who supervised the practical exercises along with the professors of the nursing department.

It was also planned to carry out an evaluation during the first two years of work which would measure the efficiency—that is, the relationship which exists between the proposed objectives—and the achieved objectives and the efficacy in terms of the cost of the activities of this nurse based on a unit of time. This evaluation is being conducted presently through direct observation of checkups by the participating nurses, and revision of the clinical histories written by those nurses in accordance with certain norms previously established for the program.

Diagram of the Nurse's Functions


Investigation
Definition of Basic Health Actions
Planning
Definition of a General Working Plan and Methodologies.
Programming
Design of the Training, Supervision and Evaluation Models of the Personnel.
Teaching Activities
Inter-Institutional and Inservice Coordination
Supervision of Personnel in Task Achievement
Evaluation of Applied Methodologies

Some other programs deserve to be mentioned in today's presentation since they show how, through joint cooperation between the different national and international organizations, projects may be developed which promote the development of women on a Latin American level. One of them is the agreement signed in 1971 between the Health Ministry of Colombia, the Pan American Sanitary Office and the Nursing Department of the Health Division of the Universidad del Valle, by means of which nurses were prepared educationally as well as service-wise in the expansion of the infant's maternal care which comprises prenatal care, care during birth, post-natal and perinatal care, management of fertility and management of growth and development.

During these four years, 200 nurses have been prepared in 12 Latin American countries. Fundamental changes have occurred in the teaching and the rendering of maternal and infant care in many of the participating countries.

Another project was that of regionalization in southwest Colombia, which was developed through an agreement between the Health Ministry, the Kellogg Foundation and the Universidad del Valle, advised by the Nursing Department of the Universidad del Valle. Three new programs were started for the preparation of nurses in the universities of the southwest region, thus increasing the training of nurses, which was 20 per year in 1968, to 100 per year in 1974.

This presentation has been meant to show only some of the projects and realizations of a specific group of women who work in the nursing field in my country. To each one of them a responsibility has been assigned on a greater or lesser scale as citizens, as professionals and as women in helping to fulfill the social and health needs of the people.

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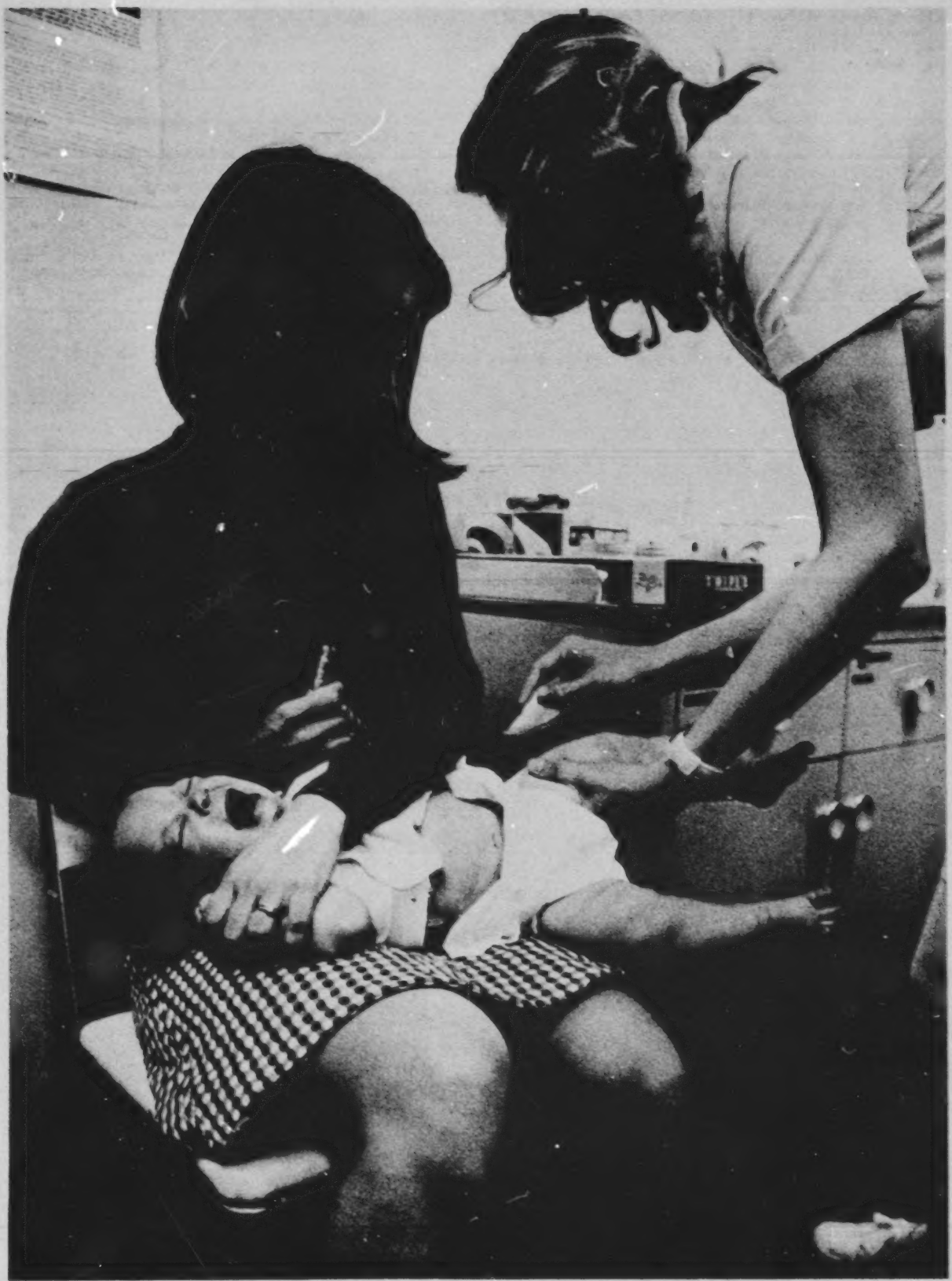

Innovations in the Utilization of Nurses, Allied Health and Support Personnel

A U.S. Response to a Look at Colombia

Ruth Roemer, J.D.
Researcher in Health Law
School of Public Health
University of California
Los Angeles, California

An impressive feature of Maricel Manfredi's excellent paper is that she deals with innovative functions on three levels: (1) expanding the skills of the highly trained professional; (2) developing a new kind of health auxiliary to perform essential functions in rural areas that are underserved by health personnel; and (3) organizing health services on a regional basis so as to create a framework in which the skills of various kinds of health personnel can be used effectively to meet health needs. Ms. Manfredi describes vividly how these three mechanisms can increase access to health services and encourage innovative functions of health personnel. Moreover, her thoughtful exploration and evaluation of the effectiveness of each of these approaches serves to advocate their adoption. These three approaches to innovative functions are relevant to both developing and highly developed countries.

In the following comments, I propose to discuss each of Ms. Manfredi's three approaches to innovative functions in the context of the United States and similar countries; to suggest some reasons as to why innovative functions contribute to improved use of personnel; and, finally, to review briefly barriers to and strategies for change.

Expanding the Skills of the Highly Trained Professional

The development of the nurse practitioner is an example of adding innovative functions to established nursing practice. In the United States, two kinds of middle-level practitioners were designed as an approach to the shortage of doctors for primary care—the physician's assistant authorized in nearly 40 States and the nurse practitioner now authorized in 20 States. As the United States experienced increased demand for health care from consumers, recognition grew that many diagnostic and therapeutic procedures could be performed safely and effectively by persons with appropriate training who were not physicians. The movement to train physician's assistants, who are generally men, developed in part because of the availability of medical corpsmen returning from the tragic war in Vietnam, but it also had a gender-related explanation in that the United States has had little success in recruiting men into nursing. The physician's assistant with a new title was a means of recruiting men for functions related to nursing. Moreover, the physician's assistant movement grew while some important segments of the nursing profession were slow to recognize the potentiality of the nurse practitioner, despite antecedents in nurse midwives, nurse anesthetists, and nurses working in intensive and coronary care units.

Unlike the United States, two other quite similar countries—Australia and Canada—have made explicit decisions not to develop a physician's assistant but rather to look to the nurse for expanded functions. Both countries have a high ratio of nurses to population and a long tradition of using nurses to provide health care in remote areas. The Bush nurse in Australia serving the aboriginal population and the Outpost nurse in the Far North of Canada are dramatic examples of independent, even heroic, functioning of nurses in providing health care. Now Australia is developing the "community health nurse" and Canada the nurse practitioner (who is called by different names in Canadian provinces). The nurse with expanded clinical skills is being developed in these countries, however, with somewhat less vigor than in the United States. This more cautious development is probably explained by the much greater strength of general practice in Australia and Canada, where approximately 50 percent of doctors are general practitioners than in the United States, where only about 25 percent of physicians in clinical practice are general practitioners.

Creating a New Type of Health Auxiliary

An example of a new type of health worker with innovative functions is the school dental nurse or school dental therapist, first pioneered in New Zealand in 1921. Many other countries, including Malaysia,

* Information in this discussion is based in part on work supported by Contract No. NO1-M1-34090(P) on "Patterns of Health Manpower Use, Education, and Regulation in Other Countries and Their Relevance for the United States," awarded by the Bureau of Health Manpower, Health Resources Administration, Public Health Service, U.S. Department of Health, Education, and Welfare.

Ceylon, Indonesia, Singapore, Ghana, Great Britain, Australia, and Canada, are now training and using school dental nurses to provide dental care to children in the schools. Factors that led to development of this kind of dental auxiliary were the poor dental health of children, the critical shortage of dentists and the reluctance of dentists even if they were available in sufficient numbers—to provide this kind of service. While the functions of the dental nurses vary somewhat among the programs and also the form and degree of supervision, two aspects of this successful innovation in use of health manpower are common to all programs. One is that in all countries young women who can develop a harmonious rapport with children are selected for this work. The other feature is that dental nurse students are trained to do standard procedures in a uniform way, so that within this defined scope of work they can exercise their clinical freedom, can work with a minimum of supervision, and thus have great pride in their work. Other health occupations and programs might well learn from the clear and realistic thinking that is the basis for the school dental nurse services of various countries.

Regional Organization of Health Services

In recognizing the importance of the system of providing health services for effective use of personnel, Ms. Manfredi has made a basic contribution to consideration of innovative functions. In all countries, health resources are finite and must be used efficiently. An erratic, wasteful, and duplicative system obstructs the effective use of personnel. Rational organization of levels of care on a regional basis according to three criteria—health needs of the population, geographic location or services, and technical requirements for different kinds of care—gives promise of using personnel wisely, encouraging innovation in functions, and assuring an equitable system of care. The Soviet Union, Great Britain, and the Scandinavian countries have well-developed systems of regionalized health services, and many other countries, including our own, are moving in this direction.

Why Innovative Functions Contribute to Effective Use of Personnel

Before turning to barriers to innovations in use of health workers, I should like to comment on *why* innovative functions contribute to more effective use of personnel and specifically in occupations in which women are the principal members.

1. Innovative functions mean new opportunities and ways to provide care, and new roles for health workers represent a flexible response to health needs. The nurse practitioner, for example, helps to increase access to primary care. The combined X-ray and laboratory technician, trained in some Canadian provinces, (who is generally a woman) meets the needs of small rural hospitals. Innovative functions thus heighten the capacity of women workers to meet health needs.

2. Innovations in functions may decrease what the Australians call "wastage" of nurses, that is, the dropping out of employment in nursing or other health fields for which the worker is trained. In Australia, more than half of the nurses graduated in the years 1957-1960 dropped out of employment in nursing in the four years from 1960 to 1964. Some of these nurses continued to work but not in nursing. While 80 percent of this attrition was ascribed to marriage and family responsibilities, other factors were job dissatisfaction, inadequate salaries, and difficult hours. Introduction of innovative functions may serve to keep some of these nurses, who would otherwise have dropped out, devoted to the field of nursing.

3. Innovative functions also provide an opportunity for creative activity. Women in new roles may be able to demonstrate their originality, their independence, or their administrative and executive skills, thus releasing talents previously not available to patients and the health service system.

4. Also, innovative functions in one group of health workers may have a stimulating impact on other members of the health team. New roles may serve as a catalyst or a source of motivation to other health personnel. For example, one of the most significant findings to emerge from a Canadian study of nurse practitioners was that the physicians with whom these nurses were working in a co-practitioner role found their diagnostic acumen and therapeutic skills challenged and sharpened by the need to communicate with the nurse practitioner on specific cases.

Barriers to Innovative Functions

Despite these manifest benefits of innovative functions, legal, economic, and attitudinal barriers may stand in the way of their adoption.

The main legal barriers relate to the licensing laws for the health professions. In the United States, State licensing laws have blocked development of new functions that are deemed beyond the scope of practice authorized for nurses in the nursing practice acts or that authorized for dental auxiliaries in the dental health practice acts. In other countries, for example in Canada, where scope of practice is not defined in nursing registration acts, there is nevertheless concern lest nurses working in an expanded role may be performing "medical acts", which are the exclusive province of the physician. Thus, new or amended legislation may be required either to authorize innovative functions or encourage adopting innovative functions in actual practice.

Economic barriers to innovative functions may also be created by the health insurance system. For example, in Canada one of the deterrents to use of nurse practitioners is uncertainty as to how the nurse is to be reimbursed. In this connection, it may be noted that in Australia physiotherapists and podiatrists are mainly women and that the number of women optometrists is on the rise; the large proportion of women in these fields may ironically have been related to the fact that these services were not covered

under the health insurance system, and men therefore, found these professions not sufficiently lucrative. One would hope that the time is ending when such economic reasons explain entrance of women into the health profession.

Finally, attitudinal barriers stand in the way of innovative functions. The opposition of senior professions—of physicians and of highly trained nurses—to delegation of functions to allied and auxiliary personnel needs to be overcome.

Strategies for Change

Strategies for change to encourage innovative functions include legislative action, economic reforms, education of the health professions, and creation of incentives for improved use of personnel. Moreover, as these strategies are pursued, efforts must be made to achieve wide acceptance of innovative functions that are deemed sound. Merely securing legal authorization or approval in principle is not enough. If the benefits of innovative functions are to help large numbers of people, new roles for health workers and new types of health workers must become the prevailing and accepted practice.

Basic to the release of women's energies for innovative functions in health services are advances in control by women over their reproductive functions. In the United States and many other countries, the potential contribution of women health workers has been greatly increased by improved methods of contraception and legalization of abortion. Without this progress in science, law, and society that means freedom from unwanted pregnancy, many of the statements made here are only hollow hopes.

What can women health workers themselves do to support and encourage sound innovations in functions of health manpower? First, women health workers need to be informed about health manpower, health services, and the total system of health care. They need to know not only their own tasks and role but how these tasks fit into the overall system and how it works. Then, on the basis of their roles and knowledge, women health workers need to participate in the decisionmaking process at all levels—as members of staffs of health agencies and facilities providing health care; as members of their professional associations influencing health policy; as members of their trade unions negotiating for satisfactory salaries and working conditions; and as citizens informing their legislators and other governmental representatives of sound practices in providing health care.

If women health workers themselves have an understanding of the total health care system and exercise their right to participate in formation of health policy at all levels and through various mechanisms, then surely not only innovative functions but other approaches will be developed to improve the utilization of women in all the health occupations, for the betterment of everyone.

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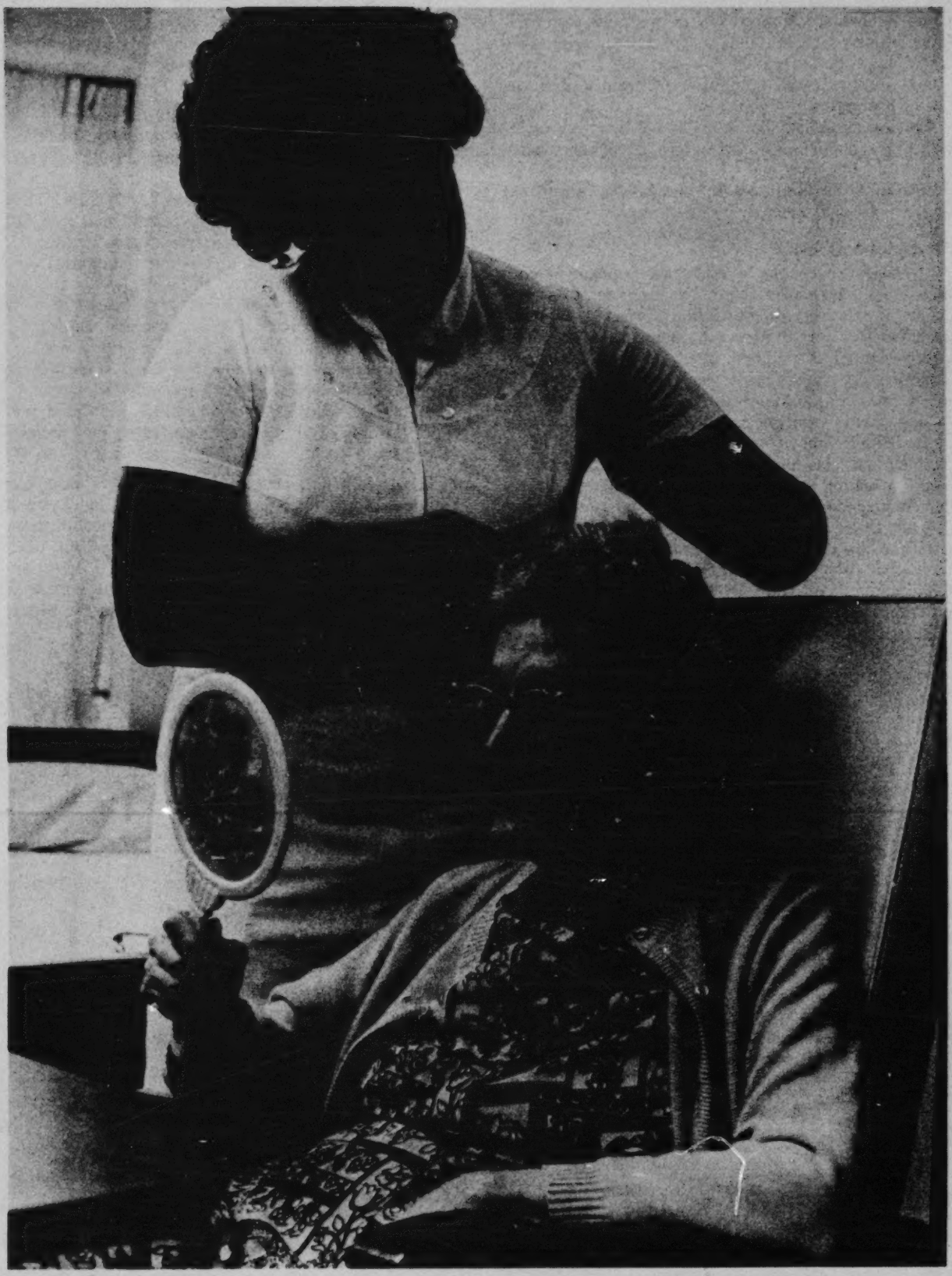

Innovations in the Utilization of Nurses, Allied Health and Support Personnel

Innovative Functions of Women Health Workers

Ellen T. Fahy, R.N., Ed.D.
Dean and Professor
School of Nursing
State University of New York
Stony Brook, L.I., New York

In attempting to discuss Maricel Manfredi's illuminating paper on innovative functions for women health workers in Colombia, I was immediately struck by the definition she provided for the traditional role of women in that country: home functions as mothers and wives, limited control of biological functions, a dearth of women in leadership positions. The definition provided could be readily applied to all American women, I dare say to women everywhere. Women have the major task before them of providing sufficient impetus for the development of a greater number of their ranks to assume leadership roles in all facets of society, political, economic and social; a greater understanding and control over their biological functions to provide continuity to this leadership and a greater sense of their collective selves.

Nowhere is the sexist question more pronounced and probably more pernicious and pervasive than in the participation of women in health care delivery. All here know that Germaine Greer said it all in *The Female Eunuch* in her chapter on "Work". In speaking of nurses:

> The most depressing phenomenon in the pattern of women's work is the plight of the nurses. Nursing began when Florence Nightingale deployed the idle daughters of the Victorian middle-class in a work of mercy which kept their hands from mischief, in the way that rich women still work for the Red Cross—The failure of this industry to evolve means that, today, in Britain 640,000 women are working for a travesty of a living wage, *doing a vital work* which requires skill, initiative and "dedication". In England, the National Health Service rests on the nurses' shoulders, remaining feasible only at their expense.[1]

Like Colombia, England and the U.S.A., nursing has enjoyed very low prestige among health care deliverers. Although our American numbers are large (794,979 in 1972),[2] and women in general comprise about 70 percent of all health workers, one can still readily find evidence that they are generally viewed as auxiliary to the doctor, kindhearted, dedicated, locked into low prestige and low potential positions. Why does this talent pool have to, like Avis, try harder? The total scope of women health workers: nurses, nursing assistants, dieticians and housekeepers and dietary workers, cleaning women, and the comparison of mean income for these same occupations with those of men, shows that the position of women as health workers hardly even parallels that of membership in the larger working force. Health services delivery in its hierarchical approach perpetuates traditional roles of women as "ancillary" to the chief high moguls, which translated in most languages means "men". Further, within that hierarchy, women health workers themselves participate and perpetuate in the continuity of the hierarchy. Thus my earlier references to pernicious and pervasive.

I am most impressed by Colombia's attempts to cope with their health problems in a geographic region through a conceptual model containing all the elements we so need in this country: preparation of indigenous workers, consumer participation, coordination of available resources through regionalization, emphasis on prevention and health maintenance via attention to populations at risk, realignment of roles and attention to low cost. I could not help but note that professional nurses and their "auxiliaries" defined by Ms. Manfredi as absolutely essential for carrying out innovation in health care delivery, are all women. Earlier in the paper can be found evidence of nursing professionals until very recently enjoying low prestige and ". . . low monetary remuneration, due to its being considered a profession with a greater number of manual than intellectual skills". Of late, nursing in Colombia has begun to enjoy greater prestige because of its social relevance, the changing role of women and progress in nursing education. Beyond the present status of nursing, the data do not make explicit the status or the future of those prepared as "auxiliaries". If one is committed to the overall position of women in innovative health care roles, then I am constrained to ask the following questions of Ms. Manfredi.

> What's in all the innovations described which will enhance the role of women as women, women as nurses and women as "auxiliary" health workers? Has the question of educational mobility for these

women yet arisen? If not, it will and should. How prepared is professional nursing to provide opportunities? How is the question of economic security being handled? Is it a totally disparate issue from the economic and general welfare of professional nurses? Have Colombian women in the total occupation of nursing begun to consider the possibilities inherent in working together to simultaneously improve the status of women and the quality of health care delivery? If these questions are presently being addressed then I apologize and turn my attention to the present status of women health workers within the occupation of nursing.

The same questions can be laid on American nursing. In this country, we too are engaged in innovative preparation of professional nurses to assume responsibility for participation in much needed primary care. 96 This seeming new-found expansion of function has all the earmarks of raising our prestige level. However, simultaneously another group known as physicians' assistants and predominantly male, is ostensibly being prepared for the same functions. Parenthetically, as Ms. Roemer points out, two other similar countries, Australia and Canada, have made "explicit decisions", not to go this route but to stick with preparing nurses for this function. Only the richest country in he world has this somewhat dubious honor. To return to innovative preparation for primary care needs: in a recent study of both workers done by the Comptroller General's Office, there is a pattern of sexist economic distinction still continuing. In an investigation of 19 programs of "Physicians' Extenders" across the country, out of a total of 71 practitioners who answered questions regarding salaries, 47 physicians' assistants earned more than $14,500 while twelve nurse practitioners reported incomes of that size. In the same study, when looking at the lower end of the pay scale ($7,000 to $8,499), out of a total of 23 respondents, 12 pediatric nurse practitioners reported the above while two PA's reported same.[3] Although the study is in no way definitive, it suggests to me that the beat goes on!

It appears then that nurses, with some hard-won advances and those designated as nursing assistants are destined to continue to enjoy second-class status because of sexist factors which are deeply rooted in the tradition of women. What then is to be lost if those engaged within the scope of nursing education and practice join together across hierarchical barriers to explore mutual problems and aspirations?

Within American nursing some of us are beginning to recognize the potential for women—power implicit in such action. We are beginning to educate nursing students and re-educate those already in practice to identify more closely with fellow workers who are women. Curriculum problems and inservice education programs, instead of just dealing with the pain and suffering of the ill and injured, are attempting to build into the educational process *greater consciousness toward recognition of the educational aspiration of all women health workers.* Some of us are fully cognizant that we represent 70 percent of all health workers. Efforts are underway to assist practicing nurses and nursing students to understand the possibilities inherent in women in general and women health workers in particular, organizing for the assumption and retention of leadership in health policy. Others are involved in assisting with gaining access to knowledge concerning biological function. For example as nursing students are learning about anatomy and physiology of the reproductive system they are assisting other women health workers to learn also. Educational objectives here are many: nursing students are learning essential content for practice, they are also learning how to "translate" what they have learned into understandable language for their future fellow workers; simultaneously they are learning the possibilities inherent in identification with the aspirations of other women health workers. Nurses, nursing students and women health workers if joined together can telescope the present struggle for health advocacy. Together they can forge the essential links between the institution designated as "hospital" (cold, masculine, impersonal, elitist, sexist), and communities (people-oriented, compassionate, non-elitist, feminine). The potential for women and for improved health care delivery is enormous.

As in Colombia, American nursing is overwhelmingly feminine in its context. As in Colombia, we are also attempting to expand educational horizons into the realm of primary care provision through opportunities to gain the knowledge and skills base of physical diagnosis. We too have experimented widely and successfully with the development of women indigenous health workers to better understand and meet the health care needs of given regions. Only in isolated instances, however, has there been serious attempts to build into their preparation, educational mobility and to address the question of financial inequity. What is called for is a concerted effort to close the social and economic distance in nursing practice between those women socialized to become "professional" and those socialized to assist as "auxiliary" to the professionals. The possibilities inherent in a greater blurring of the sharp lines of hierarchical demarcation present for us as women and nurses, one of the largest educational challenges for the remainder of this decade; if not the remainder of the century.

Undoubtedly the foregoing represents a somewhat controversial viewpoint vis-a-vis the mission of higher education and its production of the elite of any profession. Historically speaking, the evolution of elites is the process of the democratization of elites. That is, as each new transformation of social structures has taken place (as women have moved away from the wife-mother-help-meet, the role and status of nursing has changed), both the multiplicity and complexity of the problems to be dealt with and the contextual nature of the elites themselves have increased in composition and in diversity of function.

In higher education it has been assumed that a fixed educational sequence assures a better end product; that those who go through ordered and preordained

steps are better fitted for the "profession" than those who do not. Like so many other things in our country, the above assumption is being subjected to serious reappraisal within the health professions. With mounting costs and manpower shortages, formerly held xenophobic assumptions are being seriously challenged in many quarters. This in combination with the changed definition of health from a privilege for the few to an inalienable social right, is giving rise to questions about innovative and effective use of all categories of health workers.

It is now believed by some that within all the health professions, there should be the potential for educational verical mobility which will make it possible for an individual to move with comparative ease and minimum loss of time from entry level worker in a health agency, through assistant capacity, to professional practitioner. The realization of this, of course, is dependent upon the meeting of specific educational requirements and measured capabilities. The challenge is clear. Can we seize the moment? In the so-called human service professions, with manpower needs an overwhelming and continuing problem, it is doubtful that territorial imperatives, image status and professionalism, can long endure as reasons for opposing serious experimentation into this area.

It was my purpose as a discussant of Ms. Manfredi's excellent paper to raise questions, cite possible contradictions and relate opposites. It was in no way meant to negate the splendid models of health delivery described. However, until all women who work and those who plan to work begin to identify with each other and mobilize their collective energies, continued oppression is assured. The continued status of second-class citizenship is also assured. Equal pay for equal education will remain a cruel joke and the largest majority of workers in the health care industry is fated to continue its forward march into the 19th Century.

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Innovations in the Utilization of Nurses, Allied Health and Support Personnel

A U.S. Response to a Look at Colombia

Ruth Watson Lubic, R.N., M.S., C.U.M.
General Director
Maternity Center Association
New York, New York

Overview

I found Maricel Manfredi's paper both interesting and provocative. As a nurse-midwife, I am especially eager to hear of models of care which effectively deliver health services to mothers, infants and childbearing families. Therefore, I extend my thanks to those who planned this session as well as to Ms. Manfredi. It is, of course, also pleasing to note the role of women, in this instance nurses, in designing, implementing and evaluating such models. May I express my admiration of the Colombian regionalized model because it begins at the truly primary source of all health care, the home. The regionalization models proposed in the United States tend rather to begin at the tertiary or major medical center level and, by gravity, I suppose descend. In comprehensive maternity care the descent stops at the "primary" hospital, which still is an acute care general institution, not always focused on the management of normal childbearing as a health entity.

The provocative aspect of the paper relates to the manner in which the Colombian experience caused me to rethink and expand my hunches concerning the fall and rise of the midwife and nurse-midwife in the United States. My comments, therefore, will be essentially in the vein of an essay as I cull both factual information and impressions from my experience.

Differences in Reproductive Care: Colombia and the United States

In addition to the regionalization plan already mentioned, there are a number of differences between the Colombian situation and that of the United States.

1. Each country has its own unique population profile.

2. Although health care delivery problems are often acute in the hinterlands of the United States, the bulk of our population (73 percent) is urban.[1]

3. The fall in numbers of general practitioners and the power of specialist groups has resulted in a push for obstetrician delivery for all women.

4. In the United States, nurses are numerically in much greater supply than are physicians.

5. Excepting for those with ethnic or cultural differences from overriding practices, women for many years did not seek out the care of other women, or, conversely, avoid that of males. Consciously, or unconsciously, they accepted the myth of male superiority in the provision of reproductive care.

6. The most exciting recent innovations in the United States have been sparked by the public rather than professionals. Women have become extremely verbal in appraisal of in-hospital maternity care, and there is a very heady milieu of interest in "normalizing" the process of childbearing. Receiving much public attention are recent books such as *Birth Without Violence*,[2] *Immaculate Deception*,[3] and *Forced Labor*[4] which criticize depersonalized patterns of in-hospital care. Simultaneously some obstetrical practitioners are advocating universal application of fetal monitoring in order to spread the cost.[5] We wonder what the outcome of this paradox will be.

7. Finally, lay midwives, except for low-income minority women in rural areas, fell into complete disrepute early in this century. Certainly maternal mortality statistics *were* alarming and needed improvement, but one wonders in retrospect whether the lay midwife could not have been brought into the system. The decision to eliminate midwifery was motivated, perhaps not entirely, by a desire to improve patient safety. One wonders what part power, control, status and economic considerations may have played.

Innovations in U.S. Maternity Care—the Nurse-Midwife

In looking at innovation in the utilization of nurses in maternity care in the USA, one can evaluate both the addition of midwifery to nursing skills and new programs in the utilization of nurse-midwives as being innovative. Because some members of this audience may be unaware of the historical development of American nurse-midwifery, I will discuss each of these approaches briefly and then look as well at another "innovation" in the field of maternal and infant health personnel, the spontaneous rebirth of the lay midwife. In truth, women are exercising more and more authority in defining patterns of health care delivery. But the reins have been gathered up, not as much by women who happen to be health professionals, as by women

recipients of care who are increasingly making their wishes felt. We shall see that if gaps occur in the delivery system, they will be, in fact, *are being*, filled by others.

Historical Factors—The Frontier Nursing Service

To return to historical factors, I believe it is fair to say that women and nurses with subsequent support from the Children's Bureau of our Federal Government are responsible for the presence of the certified nurse-midwife in the United States today. In this country, a nurse-midwife is "a Registered Nurse who by virtue of added knowledge and skill gained through an organized program of study and clinical experience recognized by the American College of Nurse-Midwives, has extended the limits of her practice into
100 the area of management of care of mothers and babies throughout the maternity cycle so long as progress meets criteria accepted as normal." [6]

In 1925 Mary Breckinridge, a nurse who came from a prestigious family and traveled to England for midwifery education, set up a rural public health agency, The Frontier Nursing Service (FNS), to provide care to poor families in Appalachia. Nurse-midwives were imported from the British Isles in order to enable the provision of maternity care. Including delivery, in the homes of the low-income people who were being served. Those public health nurse-midwives caught the fancy of the public; the fame of the "nurses on horseback" spread across the entire country. Financial support for FNS over the years was sought and found through the medium of local committees, largely composed of women, in a number of urban areas. Recently the Service, possibly sparked by national guilt over the Appalachian poor, has been able to markedly expand its services, including the building of a modern 40 bed hospital. Mrs. Breckinridge's dedication to nurse-midwifery with its special expertise and priority for delivering humane care to childbearing families will long be remembered as the element essential to the success of this important program.

Historical Factors—Maternity Center Association

The other outstanding support for nurse-midwifery has come from Maternity Center Association (MCA), which started the first American school of nurse-midwifery in 1931. MCA is a 56-year-old voluntary health agency which was women sponsored and has always been directed and administered by women. The first General Director was Frances Perkins, later Secretary of Labor in Franklin D. Roosevelt's administration and renowned as the first woman cabinet member. The agency was administered for almost fifty years by a nurse, Hazel Corbin, throughout its period of initiating and sponsoring nurse-midwifery education. In spite of several outstanding projects demonstrating the effectiveness of nurse-midwifery care in markedly lowering infant mortality while providing satisfying care to parents, the obstetrical profession did not acknowledge the presence of nurse-midwives until 1970.

At the same time the nursing profession behaved in what might be viewed as a punitive fashion toward nurse-midwifery, refusing it any individual identity within either the American Nurses' Association or the National League for Nursing. Official nursing recognition of nurse-midwifery came in 1965, five years earlier than that of medicine, but ten years after nurse-midwifery established their own professional organization today known as the American College of Nurse-Midwives. Throughout these years then, it was not the public but rather the profession which objected to nurse-midwifery care. That care was carefully kept from any but "medically indigent" women until provider shortages were acknowledged early in this decade.

Nurse-Midwifery Today

Beginning in 1970, Maternity Center expanded its support to innovative projects in which middle and upper class women were served by an obstetrician/nurse-midwife team. This was done in order to dispel the stereotype that nurse-midwifery care is second-class care suitable only for those who can't afford "the real thing"—physician care. On-site consultants were dispatched to help develop programs at the Community Hospital of Springfield and Clark County in Ohio and at Booth Maternity Center in Philadelphia. The latter site in particular demonstrates the principles for success which Ms. Manfredi elaborated. At Booth, a free-standing, full service maternity hospital, a family centered program was developed by professionals in concert with community members. In spite of the declining birth rate, its utilization has increased five-fold since its opening just four years ago.

Over the past five years, the number of sites providing nurse-midwifery educational programs has increased from eight to 21. In addition to basic programs, nine refresher courses designed to bring back into the clinical milieu both out-of-practice U.S. prepared and foreign prepared nurse-midwives are offered. In the same period, the American College of Nurse-Midwives has increased in strength and regulatory function, providing school approval and national certification for individual nurse-midwives.

Spontaneous "Innovation"—The Return of Lay Midwifery

New innovative programs must relate to the increased public demand for more personalized, lower cost maternity care, especially for the normal childbearing family. We are seeing in the United States increasing numbers of such families "opting out" of the system in favor of home delivery. Almost by definition, home delivery is unattended by qualified professionals —few doctors are willing or able to respond to requests for domiciliary care. In addition, at least one district of the American College of Obstetricians and Gynecologists (II) has taken a position against home delivery, reaffirming the hospital as the only place for the intrapartum experience.[7] Because nurse-midwives

function in concert with their obstetrical colleagues, they are, in effect, also prohibited from providing domiciliary care. In any event, it is doubtful that a system of domiciliary care would be less expensive than in-hospital care. What we are seeing now in the United States is the spontaneous growth of an old/new profession, lay midwifery—self-taught or apprentice care—because, as I have heard lay midwives poignantly explain, "somebody *has* to help".

An Innovative Response

Maternity Center Association has developed a demonstration project which is designed to test out-of-hospital comprehensive maternity care provided by an obstetrician/nurse-midwife team, as an alternative to do-it-yourself home delivery. We estimate that care in our home-like setting can be provided at one-third to one-half the cost of in-hospital private care (ranging in New York City from $1,200 to $2,000) and we expect that our highly educational care, attuned to the needs of low-risk families will be of high quality, at least as safe as "private care". Low-risk families selecting our unit will be rescreened continually according to carefully established criteria throughout the entire childbearing experience. There is hospital back-up support and emergency transfer procedures have been tested. Labor and delivery will be accomplished in our setting, as will pediatric exam of the infant. Families will return to their homes within 12 hours; there they will be followed by the New York Visiting Nurse Service within the first 24-hours and again on the third day postpartum. Families will return to the Center on the seventh to tenth day and again at five to six weeks for the usual check of involution and institution of fertility control services. Moreover, they will be expected and encouraged to participate in decisionmaking regarding management. The patient, then, is an essential member of the team. Another essential will be the already mentioned educational component which is designed to assist women to more effectively fulfill the primary diagnostician role which is, in fact, theirs and not that of any provider. Irrespective of first contact health care worker, is not our greatest resource in health care the woman in the home? It is she, generally, who decides when any family member gets to and into the system, and who can implement preventive care on a day to day basis. The Colombian regionalization plan presented by Ms. Manfredi recognizes this fact.

Change Will Come

Is it surprising that this project, which we hope will serve as a model for provision of primary maternity care services, has stirred a great deal of controversy among professionals? But the public has taken the reins and demonstrated that *it* holds the options. Women are demanding a decisionmaking role in their personal reproductive care. Nurse-midwives, once the people "farthest out", no longer are.

This project addresses itself to all those concerns so often seen in the literature—distribution of services according to physical need, efficient team utilization of provider skills, emphasis on health education and preventive care, reduction of costs of care—(merely realigning of patterns of reimbursement is not sufficient) —care which is responsive to consumers (families) and personalized. In addition, comprehensive evaluation and ongoing utilization review are provided for. What then is wrong, why is there controversy? Why do obstetricians shout "retrogressive"? This model is successful in other parts of the world, surely it deserves a chance to be tested. Professional opposition persists in spite of approval by the duly constituted public body. Have the project's implementation problems arisen from the fact that it was conceived and designed by women, that it has been supported to date by women-raised funds? Perhaps you can answer better than I. And when I ask opponents how they would solve the "opting out" problem, I am told, "those people are ignorant; educate them."

Yesterday we heard Dr. Theodore Cooper, our new Assistant Secretary of Health, ask us as women to provide answers to serious health problems. Are you listening, Dr. Cooper?

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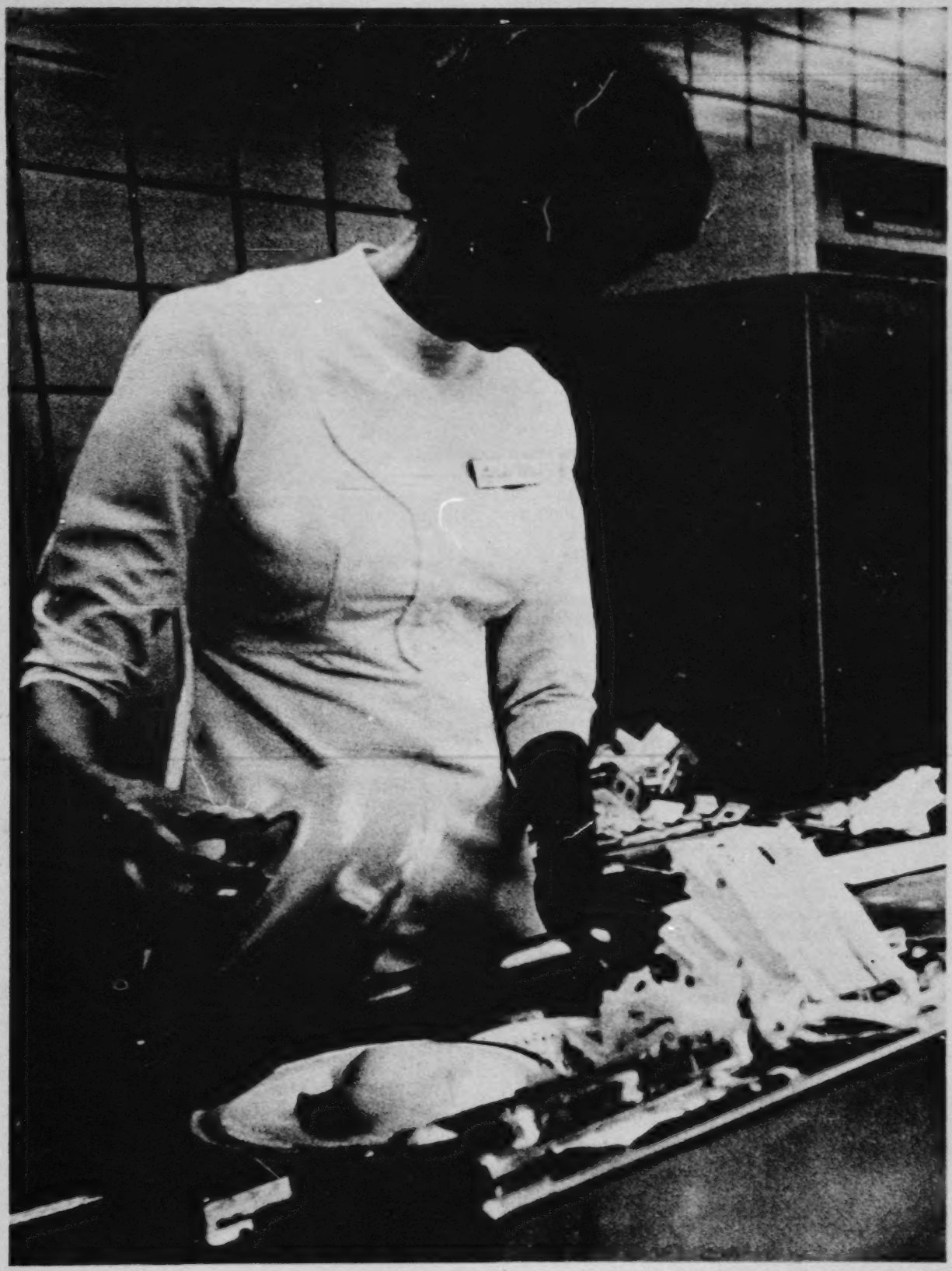

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New Roles For Women in Health Care Delivery

***Conditions in the People's Republic of China** **

Ruth Sidel, M.S.W.
Author and Lecturer
New York, New York

> Solve the problems facing the masses—food, shelter and clothing, fuel, rice, cooking oil and salt, sickness and hygiene, and marriage. In short, all the practical problems in the masses' everyday life should claim our attention. If we attend to the problems, solve them and satisfy the needs of the masses, we shall really become organisms of the well-being of the masses, and they will truly rally round us and give us their warm support.
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> Mao Tse-tung, 1934 [1]

The remarkable changes which have taken place in the well-being of the Chinese people over the past quarter century have begun to seep into the consciousness of people in the West. We are beginning to accept those reports which seemed so unbelievable four or five short years ago—that 800,000,000 Chinese are adequately feeding themselves, that the incidence of infectious disease has dropped dramatically, that drug addiction and venereal disease have been essentially elminated, that the streets are immaculately clean and beggars nowhere to be seen, that the people look healthy and, above all, seem to live and work with a sense of purpose, that, in short, the Chinese are "solving the problems facing the masses". But although this image of the New China is now generally accepted, the techniques which the Chinese have used to bring about these startling changes are not as clearly understood. This lack of understanding is in part due to the vast cultural differences between China past and present, on the one hand, and Western history, culture and development, on the other. But our lack of clear perception of the techniques the Chinese have employed since 1949, and indeed, employed in microcosm in the areas controlled by the People's Liberation Army some forty years ago, is also due, I believe, to our reluctance to see and to understand. For the Chinese experience may well have implications for other societies—implications which we prefer not to recognize.

In this paper I would like to focus on these techniques; on decentralization, on deprofessionalization, on self-reliance and mutual aid, on massive efforts to educate the entire population about health, on mass participation in health care, and on extensive use of indigenous non-professionals to do preventive work and provide primary care. I will also explore the effect that adherence to these basic principles has had in opening participation in the health field to people of all classes and particularly to women. It is only through an understanding of the basic principles of the Chinese Revolution that we can gain some understanding of the new roles for women in health care delivery in that society. But first a brief look at the "bitter past".

"The Bitter Past"

The Chinese never speak simply of the past but always of the "bitter past", a time when the country was plagued with almost every known form of infectious and nutritional disease, including cholera, leprosy, tuberculosis, typhoid fever, plague, beriberi and scurvy; when venereal disease and drug addiction were widespread; a time when, according to one observer, China suffered four million "unnecessary" deaths each year.

To have some conception of the problems which faced the new Chinese government when they took power in 1949, commonly referred to as the Liberation, one must first have a glimpse of the conditions under which people lived twenty-five short years ago. According to Theodore H. White and Annalee Jacoby, reporters in China during World War II:

> The cities reeked of opium; cholera, dysentery, syphilis, and trachoma rotted the health of the people . . . sewage and garbage were emptied into the same stream from which drinking water was taken . . . Dust coated the city (Chungking) almost as thickly as mud during the wintertime. Moisture remained in the air, perspiration dripped, and prickly heat ravaged the skin. Every errand became an expedition, each expedition an ordeal. Swarms of bugs emerged; small green ones swam on drinkng water, and spiders four inches across crawled on the walls. The famous Chungking mosquitoes came, and Americans claimed the mosqui-

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** Portions of this paper have been drawn from *Serve the People: Observations on Medicine in the Peoples Republic of China*, by Victor W. and Ruth Sidel (Boston: Beacon Press, 1974) and *Families of Fengsheng: Urban Life in China*, by Ruth Sidel, (Baltimore, Md., Penguin Books, 1974).

toes worked in threes; two lifted the mosquito net, while the third zoomed in for the kill. Meat spoiled; there was never enough water for washing; dysentery spread and could not be evaded.[2]

Rewi Alley, a New Zealander who has lived for many years in China, describes child laborers in a light-bulb factory:

> There are nine factories in the immediate vicinity of this one, each packed to capacity with child workers amongst whom skin disease, such as scabies and great festering legs due primarily to bed bug bites, are very common. I was especially struck by the bad condition of two little boys whose beri-beri swollen legs were covered with running sores, and whose tired little bodies slumped wearily against the bench after they have moved to answer my questions.[3]

In addition to the cruel poverty under which the Chinese people lived, which created some and exacerbated most of their health problems, there existed a woefully inadequate number of medical personnel and hospital facilities. The history of medical manpower in China before Liberation is a dual one. On the one hand, it is the history of traditional Chinese medical practitioners who by legend were practicing herb medicine some thirty centuries before the beginning of the Christian era; on the other hand, it is a history of the introduction from abroad of what the Chinese call "doctors of Western medicine," followed by the training of such doctors in China.

The practitioners of traditional Chinese medicine varied greatly in their training and skills, and the absence of any well-defined national qualifications for those doctors prior to Liberation makes it very difficult to estimate their number. When qualifications for doctors of Chinese medicine were formally defined by the government in 1955, the total number for the entire nation was given as 486,700.[4] It is, therefore, not unreasonable to estimate the number of traditional doctors in 1949 at about 500,000, or about one for every 1,100 of the estimated 540 million population at that time.

Although the definition of a doctor of Western medicine is considerably simpler, estimates of their number are almost as varied as those of traditional doctors.[5,7] An educated guess places their number at no more than 20,000, leading to a Western doctor-population ratio in 1949 of no more than 1:25,000. Furthermore, most of the doctors trained in Western medicine who did exist practiced in the cities of the east coast, leaving almost no Western-type doctors in the rest of China.

Among these Western-trained personnel were women, who played a role in medical care in China long before other fields were open to them. In the 1890's a small group of women studied to become physicians in the United States under missionary auspices. Despite a social climate that surely was not conducive to their acceptance in a profession such as medicine, the women doctors were remarkably successful—in part, no doubt, due to the reluctance of Chinese women to be treated by male physicians.[8] From 1934 until 1946 there was a steady increase of women in health work and by 1946 the health field, in which 27.8 percent of the students were women, was the third most popular profession for women; it is unclear, however, from available statistics what percentage of women were physicians and what percentage were other types of medical workers.[9] In 1958, women constituted 40.2 percent of the student body in the fields of medicine and pharmacy, while in literature, art, and education they constituted only 22.2 percent. [10] Women also functioned as midwives, particularly in the rural areas; in 1952 it was reported that in 1950 alone 46,371 old-style midwives were re-educated".[11]

Hospital facilities in which medical manpower might practice were similarly limited. The range of estimates of the number of hospital beds in 1949 is wide; a recent one given by Chinese physicians visiting Canada in 1971 was 90,000,[12] or one bed for every 5000 people. In short, the only medical care available to the vast bulk of China's population who lived in the rural areas and to most of those who lived in the cities was provided by traditional practitioners and herbalists, many of them inadequately trained even in traditional Chinese medicine. Even where Western-type facilities existed, superstition and ignorance often kept people from using them. Preventive medicine was almost nonexistent,[13] and the cycle of poverty, disease, and disability seemed to many to be endless and immutable.

Development of Health Services After 1949

When the Communists took power in 1949, one of their first priorities was the provision of more adequate medical care. At a National Health Congress in Peking in the early 1950's four principles were adopted, which remain the foundation on which medical policy is determined:

1. Medicine must serve the workers, peasants, and soldiers.
2. Preventive medicine must be given priority over curative medicine.
3. Practitioners of Chinese traditional medicine must be united with practitioners of Western medicine.
4. Health work must be integrated with mass movements.

This last principle is of great importance because the Chinese leaders recognized that the great mass of the Chinese people had to be educated about health—about sanitation, infectious disease, venereal disease, principles of public health—for a revolution in health to take place. They recognized that a dramatic change in the health care of China's vast population could not be superimposed from above. And so they set about involving people in their own health care.

This firm belief in popular participation and in the efficacy of learning through doing has been a crucial part of Chinese Communist philosophy since the Yenen days. As early as 1937 Mao Tse-tung stated in his essay "On Practice":

> If you want knowledge, you must take part in the practice of changing reality. If you want to know the taste of a pear, you must change the pear by eating it yourself. If you want to know the structure and properties of the atom, you must make physical and chemical experiments to change the state of the atom. If you want to know the theory and methods of revolution, you must take part in revolution. All genuine knowledge originates in direct experience.[13]

Thus, while the mobilization of the masses has been the primary technique by which the Chinese have accomplished their feats of engineering—the construction of their canals, bridges, large-scale irrigation projects, and dikes and the damming of rivers—it has also been the primary mechanism in their feats of human engineering. Han Suyin describes the process of education of the masses since 1949 as one that has included the "eradication of the feudal mind" and "getting the masses away from the anchored belief that natural calamities are 'fixed by heaven' and that therefore nothing can be done to remedy one's lot". She continues: "To bridge this gap between scientific modern man and feudal man, the prey of superstition, and to do it within the compass of one generation, is a formidable task".[14] One of the prime techniques used to accomplish this "formidable task" has been the activating of the people. In health care this has meant the broadest involvement of people at every level of society in movements such as the Great Patriotic Health Campaign. Another technique has been the recruitment from the population they are to serve of selected groups of people such as barefoot doctors in the countryside, Red Medical Workers in the cities, and worker doctors in the factories.

During the first decade and a half of Communist rule unprecedented changes took place in the health and health-care system of China. Cholera, plague, smallpox, and most nutritional illnesses quickly disappeared; opium addiction was eliminated, largely through community-based efforts; venereal disease took somewhat longer, but through a combination of social and medical techniques was reportedly almost completely wiped out in most of China by the early 1960's. Through the Great Patriotic Health Movements, the people were mobilized against the "four pests": flies, mosquitoes, rats, and bedbugs. As the process was described in 1971, "old customs and habits of the people were changed," "society was remolded," and "a new social attitude of 'regarding hygiene as an honor' took root among the mass of our people".[15]

Health care personnel were trained at an astonishing rate. It is estimated that over 100,000 doctors were trained in less than twenty years and large numbers of assistant doctors, nurses, midwives, pharmacists, and radiology and laboratory technicians as well.

But despite these incredible advances that took place during the first fifteen years of Communist rule, the Chinese medical establishment was severely criticized during the Cultural Revolution. Mao Tse-tung singled out the Ministry of Health for criticism in a statement made on June 26, 1965. In his statement Mao urged a shorter period of time for medical education, that more time and effort be devoted toward "the prevention and the improved treatment of common diseases," and particularly castigated the medical establishment for neglecting the needs of people in the countryside. The final sentence of the statement, which has come to be known as simply the "June 26 Directive", is: "In medical and health work, put the stress on the rural areas!"

Since the Cultural Revolution (1966-1969) the Chinese government has attempted to redress the balance between life in the cities and life in the rural areas.[17] In medical care this has meant increasing the number of hospitals and hospital beds, sending mobile medical teams from the cities to the countryside and training large numbers of "health workers" and barefoot doctors.

The Barefoot Doctor

In 1958 the entire countryside of China was divided into communes—formal, self-contained political units, with their own internal governments. Communes are subdivided into production brigades which in turn are subdivided into production teams. The commune is the lowest level of formal state power in the rural areas and is responsible for the overall planning, education, health and social services for its population.

Efforts to train indigenous rural personnel who would participate in agricultural production and at the same time deliver health care actually began in the late 1950's. For example, in 1958, as part of the Great Leap Forward, physicians in Shanghai organized themselves to go to nearby rural areas, where, in cooperation with the clinics of the people's communes, they trained in short-term classes and through practice, large numbers of health workers who did not divorce themselves from production. Figures for June 1960 show that there were over 3,900 such health workers in the more than 2,500 production brigades of the ten counties under the Shanghai municipality.[18]

During the period 1961-65 there was said to have been a cessation of training and a reduction in the number of such health workers. A report, now criticized as "revisionist", "counter-revolutionary", and "malicious" was issued that condemned the role of the health workers in the production brigades and suggested that it would be better if they dropped their medical work and devoted themselves to agricultural tasks. The 3,900 health workers in the Shanghai counties were, therefore, reduced in number to just over 300. In the months immediately preceding the Cultural Revolution the training of rural health workers was

apparently resumed, and by the time Mao Tse-tung issued his "June 26th Directive" in 1965 the number of health workers in production brigades of the Shanghai counties had increased to more than 2,300.

The training of barefoot doctors began in earnest following Mao's directive. The term "barefoot doctor" *(chijiao yisheng)* looses much in translation; barefoot doctors are neither barefoot nor doctors. The word, *chijiao*, barefoot, is used to emphasize that the barefoot doctor is indeed a peasant rather than to describe the lack of footwear. To quote directly from a definition provided in English by the Chinese themselves: "A 'barefoot doctor' is a peasant who has had basic medical training and gives treatment without leaving productive work. He gets the name because in the south peasants work barefooted in rice paddies".[19]
106 The reader should also not be confused by the translation of *yisheng as* "doctor", which it indeed means in other contexts. Chinese officials do not equate the *chijiao yisheng* with regularly trained doctors: the former are counted in statistics as peasants rather than as health workers. Their patients similarly are said to understand the differences. They refer to their barefoot doctor not as *yisheng* or *daifu* (which also means doctor), but as *tongzhi* (comrade), the common form of address for everyone in China, including doctors.

Still using the Shanghai countryside as the example, by 1968 there were 4,500 barefoot doctors who themselves had trained more than 29,000 peasants as auxiliary "health workers" for the production teams. In 1971 the 2,724 production brigades in the rural counties of the Shanghai municipality were served by 7,702 barefoot doctors. Their number had apparently increased markedly throughout China, for there are now said to be "over a million" barefoot doctors and the Chinese are very proud of their work. Unlike the attitude of Soviet health officials, for example, who are attempting to "phase out" workers such as the feldsher,[20] or at least give them a more limited, technical, subordinate role,[21] the Chinese feel that the barefoot doctor is playing an indispensable role in health care and is likely to continue to do so for many years to come.

As in the current recruitment of medical students in China, barefoot doctor trainees are chosen by those whom they will serve. Political ideology and a desire to "serve the people" are said to be of major importance in their selection; while these are ideological qualities, the teams and brigades seem to be attempting to select individuals who genuinely want to care for others. Barefoot doctors frequently mention the honor they feel on being chosen for training by their fellow production team or brigade members.

Because ideology and the desire to serve rather than specific skills are prime qualifications in the selection of the barefoot doctor, and the Red Medical Worker and the worker doctor as well, these jobs are open both to men and to women. The lower level of education and lower level of skills which were a legacy to the vast majority of Chinese women from pre-revolutionary China are not the impediments to becoming health workers that they would be in other more highly technical fields. The 1962 report of the Third Kwangtung Provincial Woman's Congress describes the special disadvantages of women workers:

> In mobilizing women to take part in production, we must in consideration of the special conditions of women, adopt various appropriate measurers . . .Generally speaking, owing to the influence left over from the old society, women's cultural standards were relatively low; they were haunted by an inferiority complex and seldom had an opportunity to participate in social activities.[22]

The very characteristics which the Chinese seek in the recruitment of paramedical personnel—closeness to the other members of the community, revolutionary fervor, a desire to "serve the people," a quality of caring—are as likely to be found in women as in men. As Joshua Horn has said, the qualities stressed in barefoot doctors are ones "of selfless service to the people, of limitless responsibility in work and of perseverance in the face of difficulties. The intention was not merely to impart medical knowledge", Horn continues, "but to evolve a new kind of socialist-minded rural health worker who would retain the closest links with the peasants and be content to stay permanently in the countryside".[23] Many Chinese feel, furthermore, that the qualities of caring and patience often thought to be desirable characteristics in medical workers are more likely to be found in women than in men.[24]

The barefoot doctor's role as a production brigade member, a peasant who spends most of the time during planting and harvesting seasons doing agricultural work, must be stressed. In slack periods, however, a considerable part, often more than half of the time, is spent catching up on the health needs of the production brigade, particularly in the areas of environmental control and preventive medicine. The barefoot doctor is considered by the community as a peasant who performs some medical duties rather than as a health worker who does some agricultural work. Herein, as well as in length and content of training and in certain aspects of the job description, lies the difference between the barefoot doctor and the Soviet rural feldsher.[25] [26] The feldsher is clearly thought of, and thinks of himself, as a health worker in rural practice. As a result he feels put upon if he is required to do any nonmedical work. The view was effectively presented in a 1968 story, "Hay is Our Main Concern," in *Krokodil*, the Soviet satirical journal.[27] In this story, the feldshers are required to cut grain to feed their own horses, a task they obviously consider a waste of their time and medical training, as well as—though it is not explicitly stated—below their dignity.

Neither should the barefoot doctors be confused with the medical assistants of certain countries of Africa and the South Pacific who, like feldshers, spend essentially full time in health and medical care [28] and are separated in a number of tangible and intangible ways from the people they serve. Few parallels to

the barefoot doctors exist in other countries; where they do exist they are usually called "auxiliaries".[29]

Despite the time spent doing medical work, barefoot doctors receive wages on a scale similar to agricultural workers. A commune member's income depends on the total income of the commune and the number of work points he collects. Barefoot doctors generate work points by doing medical work just as though they had been doing agricultural work during the same period. Like fellow commune workers, barefoot doctors receive an equal share of the distributed produce of the commune, and cash from its sale of produce based on the number of work points they have collected.

As a peasant, the barefoot doctor's income is lower than that of the doctors working on the commune, who are not considered to be peasants. Beginning doctors now earn a salary on the order of 600 *yuan* (about U.S. $240) a year compared to the 300 *yuan* or less earned annually in cash by the peasants, including the barefoot doctors. Since the cash income of the barefoot doctor and other commune members is supplemented by distribution of produce, however, and since the cost of living in the communes is said to be much lower than in the urban areas, the differences may be less marked than they appear.

The training of the barefoot doctor varies from commune to commune. Formal training ranges from three or four months periods in successive years, interspersed with on-the-job supervision and guidance, to a single three-to-six-month period of training followed by a variable period of on-the-job experience. The formal training period is usually taken in a county or commune hospital and is fairly evenly divided between theoretical and practical work. As seems to be true of most job requirements in present-day China, there appears to be little emphasis on particular duration or type of training, and even less on earning a specific credential or degree; rather, it is on the skills an individual demonstrates in a particular job situation.

As with the educational pattern of regular doctors, there is said to be little stress on grades and competition among the students. Each is expected to help fellow students who may be slower at learning the material or the techniques. In any event, since each barefoot doctor returns to his own production brigade to work, there would appear to be little advantage in scoring academic points. The impetus for learning comes from the students' recognition that they will be responsible for the health of their fellow workers after they return to the commune; this, we were told, provides the incentive to learn, rather than examinations or grades.

On returning to the commune there apparently follows a period of fairly closely supervised work. A most important part of the training is felt to be the barefoot doctor's regular work with trained doctors in the commune hospital and health center. The nature of this training varies from commune to commune, ranging from the barefoot doctor spending one day a week to as little as one day a month at the center.

As with their training, barefoot doctors' duties vary from area to area, commune to commune, and even brigade to brigade within the same commune. There are, however, many standard activities. In general they have responsibility for environmental sanitation, health education, immunizations, first aid, and aspects of personal primary medical care and post-illness follow-up.

With regard to environmental sanitation the barefoot doctor is responsible, for example, for the proper collection, treatment, storage, and use of human feces as fertilizer. While these tasks are usually carried out by health workers who were trained by a barefoot doctor, the work is inspected regularly by the barefoot doctor. Barefoot doctors are responsible for directing campaigns against such pests as flies, cockroaches, fleas, or snails, and they or the health workers visit the homes of commune members regularly to spray insecticides. Health education efforts include teaching hygiene to fellow commune members. 107

The training and responsibilities of Liu Yu-sheng, the twenty-eight-year-old barefoot doctor of the Double North Production Team (population 509) of the Double Bridge People's Commune near Peking are fairly typical. After graduating from junior middle school Liu worked in the production team as a peasant. When in 1965 Mao Tse-tung issued his June 26th Directive to put stress on medical care in the rural areas, Liu was elected by the members of the team to be trained as a barefoot doctor. He was trained for three months in his commune by mobile teams of doctors from urban hospitals. Since he began his work, Comrade Liu has had short leaves of absence for further study, and recently he went to Peking for three months to study traditional Chinese medicine. He focuses on prevention, health education, and the treatment of "common diseases".

Immunizations are an important responsibility of the barefoot doctor, although again they are often done by the health workers under supervision. At the health center of the Mai Chai Wu Production Brigade of the West Lake People's Commune near Hangchow, Mai Jen-Chai, one of the brigade's two barefoot doctors, keeps detailed immunization records for each child in the 251 families of the brigade; as in the cities, the immunizations are for diptheria, pertussis, poliomyelitis, measles, smallpox, meningococcal meningitis, and Japanese B encephalitis.

The barefoot doctor is usually readily available for medical emergencies since he normally works in the fields with his patients and lives among them. Comrade Mai reported that he treats colds, bronchitis, gastrointestinal disorders, measles, and minor injuries; more complicated problems are referred to the commune health station. The auxiliary health worker applies dressings for minor injuries and gives medication for headaches, colds, and fever.

Hsiao Hsiu-yun, a twenty-two-year-old barefoot doctor at the Taiping-chiao Production Brigade of the China-Rumania Friendship People's Commune southwest of Peking, was trained in the commune hospital

for three months beginning in January 1970. She and thirteen other barefoot doctors care for the "light diseases" of the brigade's 2,900 people.* They take turns staffing the sparsely furnished, three-room brigade health station from 7:30 a.m. to noon, and again from 2:30 to 7:00 p.m. In addition, one of them is always on duty at the health station during the lunch break, after seven in the evening, and all night.

These barefoot doctors immunize all the brigade's children from the ages of one to seven; the immunization records are kept on cards in the health station and are filed according to production team. While the brigade midwife delivers the babies, according to Comrade Hsiao, the barefoot doctors are responsible for educating the brigade women about family planning and providing them with contraceptives. They also plant
108 traditional Chinese medicinal herbs, go to the mountains to collect additional herbs, make up pills, prepare injections and fill and label the vials.

In the communes the brigade midwife, invariably a woman, receives training similar to that of the barefoot doctor and has equal status. She provides prenatal care and health education, and performs uncomplicated deliveries. Midwives give special attention to education in, and encouragement in the use of, birth control methods. For example, Kao Ning-shin is the midwife for the Sing Sing Production Brigade of the Horse Bridge Commune outside of Shanghai. The brigade consists of 1,850 people and in 1971 was served by four barefoot doctors and one midwife. Comrade Kao is thirty-three. In 1966 at age twenty-six she received a three-month midwifery course at the county hospital. She usually performs two or three deliveries a month and returns to the county hospital one day a month for further training.

The Red Medical Worker

Cities are decentralized in much the same way as are rural areas. Cities are governed by revolutionary committees, which are formal governmental bodies; their health services are coordinated by the local bureau of public health. The next lower levels of urban organization are "districts" which are subdivided into "neighborhoods", the lowest level of formal governmental organization in the city. The responsibilities of neighborhood committees include the administration of local factories, primary schools, kindergartens, a housing department, a neighborhood hospital or health center and supervision of the residents' committees. The residents' committee is a "mass organization" with elected indigenous leaders rather than a formal governmental body.

For example, the Fengsheng neighborhood in Peking's West District has a population of 53,000. The people are grouped into twenty-five residents' committees each of which encompasses about 2000 people. These committees provide health and other social services. The health workers at the residents' committee level are former housewives who have been trained to be Red Medical Workers. A large part of the duties of the Red Medical Worker, under the supervision of the Department of Public Health of the neighborhood hospital, relates to sanitation work in the neighborhood. As part of the Great Patriotic Health Campaign here are ongoing campaigns particularly in the summer against flies and mosquitoes, and attempts are made to prevent the spread of gastrointestinal disease. The entire population is mobilized under the supervision of the Red Medical Workers to keep the neighborhood clean, with special cleanup days set aside, especially around the May 1 and October 1 celebrations. In the winter and spring the health workers are concerned mainly with the prevention of upper respiratory infections. Some health stations organize mass meetings and study groups to educate the people about infectious disease; people are taught to report all infectious disease to the health station immediately.

The Public Health Department also supervises the Red Medical Workers in providing immunizations which are usually given in the residents' committee health station. The Red Medical Workers will often go to the homes to bring the children to the health station for immunization, and, if necessary, may give the immunization in the home. It is considered the responsibility of the health workers as well as that of the parents to make sure that all those eligible for immunization are, in actuality, immunized. Perhaps it is this mutual feeling of responsibility on the part of both the citizen and the health establishment that accounts for the incredible immunization rate and subsequent drop in infectious disease in China.

The Red Medical Workers also have as their responsibility the provision of birth control information. They give out oral contraceptives directly, often with no specific medical examination prior to initiation of treatment. Intra-uterine contraceptive devices are available, and insertion is performed by trained personnel in the neighborhood hospital. Red Medical Workers make periodic visits to all of the women of the residents' committee area encouraging the use of contraception and discussing with them the need to lower China's birth rate and the importance of "planned birth" in the liberation of women. If women are burdened by bearing and caring for many children, they say they cannot be part of society and make their contribution to the society.

In one neighborhood in Hangchow, for example, health workers trained by Red Medical Workers go door to door talking with women about the number of children they plan to have and the birth control methods they are using. By means of monthly visits to the home of each woman of "childbearing age," which is

* This commune, with a population of 46,000, had trained 450 barefoot doctors. That ratio of approximately 1:100 (or 1:200 in the Taipingchiao brigade) was the highest we observed in China. The 7,702 barefoot doctors in the rural areas of the Shanghai municipality, for example, serve 4.7 million people, a ratio of about 1:600; the latter ratio is more consistent with the overall estimate of "1 million barefoot doctors for China's 750-800 million people.

defined as the time from marriage to menopause, the Red Medical Workers keep careful track of the contraceptives used. Abortions are free and easily available but are rarely requested by unmarried women; pregnancies among unmarried women are said to be exceedingly rare; out-of-wedlock births are essentially unheard of.

The Red Medical Workers also care for patients with "minor illnesses" and provide follow-up care after a patient has been treated in a hospital. For example, one day Red Medical Workers were treating patients with arthritis using a combination of acupuncture and herb medicine and were also checking blood pressures in patients with hypertension to determine the appropriate dose of medication. The therapy for these patients had been started in the neighborhood or district hospital and the continuing dose of medication prescribed there. The Red Medical Worker may herself change the type of traditional medicine given to a hypertensive patient, but can vary the dose of Western medicine only within certain limits. If the patient's blood pressure is found to be outside the limits set by the hospital, the patient is sent back to the hospital for treatment and new instructions.

Red Medical Workers serve the fifteen hundred people who live in the Wu Ting Residents' Committee, located in the western part of the Fengsheng Neighborhood. The Wu Ting health station is located in a single room off one of the courtyards. Its fairly typical equipment includes a bed for examination or treatment, a table with chairs at which consultations may occur and a cabinet with both Western-type and traditional Chinese medicines. On the walls are a picture of Mao Tse-tung, an acupuncture chart, and health-education posters.

One of Wu Ting's Medical Workers, Yang Hsio-hua, is thirty-eight-years-old. After her marriage she worked briefly as a saleswoman until age nineteen, when her first child was born. Since then she has been home taking care of her children, now ages nineteen, fifteen, and eleven. Two years ago, responding to a call to "Serve the People", which grew out of the Cultural Revolution, she volunteered for one month of training in the Fengsheng Neighborhood Hospital. During the training period she and her fellow housewives learned history-taking and simple physical examination techniques, such as blood-pressure determination. They were taught the uses of a number of Western and herb medicines and techniques of acupuncture and of intramuscular and subcutaneous injection. Preventive measures, such as sanitation, immunization, and birth control techniques, were an important part of the curriculum. But the most important part, according to Comrade Yang, was that she and her colleagues were taught that there are no barriers between them and the acquisition of medical knowledge other than their own fears. Once these are overcome, in part by sessions in which the "bitter past" and the feelings of the students are shared and discussed, the housewives feel it is indeed possible to become medical personnel.

Comrade Yang continues to learn from a doctor from the neighborhood hospital who visits the residents' committee health station three times a week, from her own periodic visits to the hospital about a patient or for instruction, and from the bi-weekly or monthly meetings of all the Red Medical Workers of the neighborhood.

Another Red Medical Worker of Wu Ting is Chang Cheng-yu, a forty-three-year-old mother of two children, ages twenty-one and twelve. She has been a housewife all her married life and never worked outside the home until she became a health worker. Both Comrade Yang and Comrade Chang live in the residents' committee area within a few steps of the health station. The station is staffed by them and their colleagues during the morning and again in the afternoon. If a patient does not feel well during the times when the health station is closed, the patient can go directly to the home of one of the Red Medical Workers, although this evidently happens rather rarely.

The health workers are paid a modest sum for their work, about fifteen *yuan* per month, roughly one-third the wages of a beginning factory worker. These wages come in part from the small payments made by patients visiting the health station and in part from the collective income from the neighborhood factories.

The Worker Doctor

China's factories have highly organized medical services and are major sites of health care in the urban areas. Most factories have a central clinic as well as health stations in individual workshops; often there is a factory hospital with beds for short-term stays. The worker doctor is the analogue in the factories of the Red Medical Worker and the barefoot doctor; just as peasants are chosen by their peers to become barefoot doctors, factory employees are chosen by their fellow workers to become worker doctors. The formal training seems in general to be shorter than that of the barefoot doctor and a little longer than that of the Red Medical Worker, usually taking about a month. Continuing on-the-job supervision and training is considered extremely important. The worker doctor has the responsibility of health education, preventive medicine, and the treatment of minor complaints, which are often taken care of right in the workshop.

At the Fengsheng Neighborhood Insulation Material Factory in Peking, Tung Shih-ping, a young woman of eighteen is the worker doctor to 190 workers. Comrade Tung attended primary school for six years and middle school for three years, graduating in 1970. She came to work in the factory in July of the same year, and shortly thereafter was chosen by the factory's revolutionary committee to be trained as a medical worker. Starting in November 1970 she was trained at the People's Hospital for three months.

Comrade Tung does "mainly preventive work, some sanitation work, and treats 'light diseases'." She takes blood pressures and temperatures, and has a variety of medicines with which to treat minor illnesses. The

medicine cabinet in the small room that serves as her medical station is filled with approximately fifty Western medicines and forty traditional medicines. If there is an emergency Comrade Tung will refer the worker to the Fengsheng Neighborhood Hospital; if the patient fails to improve he will be referred to the district-level People's Hospital. Patients with certain illnesses can be referred directly to a specialty hospital.

Comrade Tung also does family planning work among the women workers in the factory. She stressed that birth control is a matter of free choice, but that she tries to educate the women about family planning. If a woman has one girl and one boy, she encourages the woman to use the pill, which she provides, or have an intra-uterine device inserted in People's Hospital. "However, if the woman has two girls, she usually wants another child to try for a boy."

The Peking Printing and Dyeing Mill is a much larger factory. Forty-four medical workers—two Western-trained doctors, four assistant doctors, one pharmacist, nine nurses, and twenty-eight worker doctors—are available to care for 2,000 workers and their families. The two doctors attended regular medical colleges, and the four assistant doctors attended middle medical colleges. The salary for fully-trained doctors ranges from 46 *yuan* a month for a beginning doctor to 170 *yuan* a month for the most experienced. The assistant doctor's salaries begin at 32 *yuan* a month, as do the nurses' salaries, and rise to 80 *yuan* a month.

The worker doctors, on the other hand, are paid at the same rate as regular workers on a scale ranging from 34 *yuan* a month for the beginner to 240 *yuan* for the most experienced. The twenty-eight worker doctors were trained for three months, full-time, in a People's Liberation Army hospital in 1969 and have since had training in ear, nose, throat, and eye diseases, and in traditional Chinese medicine in specialty hospitals. They were chosen by their fellow workers and received full pay during their training period.

Summary

A major effort has been made in China particularly since the onset of the Cultural Revolution to provide increased services to those who formerly had least—the vast rural population and the urban poor. The development of new types of health workers—the barefoot doctor, the Red Medical Worker and the worker doctor—is at least a partial solution to the problem of bringing medical care to China's people.

Another important goal has been the involvement of large numbers of people in health care both in order to make dramatic, immediate improvements in the health of all of the people and to change people's views about the nature of the universe and the role they can play in altering their environment. John G. Gurley, an economist, has described China's current view of "mass participation":

> To gain knowledge, people must be awakened from their half slumber, encouraged to mobilize themselves and to take conscious action to elevate and liberate themselves. When they actively participate in decisionmaking, when they take an interest in state affairs, when they dare to do new things, when they become good at presenting facts and reasoning things out, when they criticize and test and experiment scientifically, having discarded myths and superstitions, when they are aroused—then the socialist initiative latent in the masses [will] burst out with volcanic force.[80]

The Chinese emphasis on decentralization and on self-reliance has meant that communes and urban neighborhoods must take responsibility for planning health sources for their own people. This belief in decentralization combined with the reliance on mass participation and deprofessionalization has led to an involvement in health of every segment of the society—the peasant, the worker, the "housewife", the formerly educated and unskilled, as well as the highly educated professional.

Women have become a significant force in the provision of medical care in China. It is said that half of the barefoot doctors are women; all of the midwives, nurses and Red Medical Workers are women. Women comprise 30-40 percent of all physicians and 50 percent of all medical students. Conditions in China are favorable to the involvement of women in health work. While most Chinese women marry and bear children, supports exist within the family and within society to enable them to work outside of the home. Most families in China are three-generational with grandmothers available to help with housework and child care. Urban women, and to some extent rural women as well, are entitled to extensive prenatal and post-partum care and to paid maternity leave. A widespread system of preschool care exists, particularly in the cities, and after-school activities for primary school children are frequently provided by the neighborhoods. But what is probably most valuable in enabling a mother to participate in health care is the belief in multiple or shared mothering, the belief that a warm parent-substitute can provide the necessary nurturing for the healthy development of the child. Fathers are encouraged to participate in this nurturing process as well and are slowly becoming more involved.

From the earliest days of the Chinese Revolution the Chinese have recognized that involving women actively in society was a complex problem. They recognized that women, by virtue of their particular "bitter past" and their biological role as mothers, needed special circumstances and encouragement in order to move out of their private courtyards into the larger society. The Chinese practice of decentralizing and deprofessionalizing health care in the communes, the urban neighborhoods and the factories enables those who live and work there to participate in delivering medical care while remaining close to their homes and families.

Thus, women are indeed participating in solving the "practical problems in the masses' everyday life" and, in doing so, are liberating themselves. For it is the

Chinese view that the liberation of women cannot be viewed separately from the liberation of all of the people. As Soong Ching-ling has stated: "The Women's Liberation Movement will be ended when and only when . . . the process of the social transformation of society as a whole is completed".[31]

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New Roles for Women in Health Care Delivery A U.S. Response to Conditions in the People's Republic of China

Roles for Women Health Workers in the U.S. and China

Carol A. Brown, Ph.D.
Assistant Professor
Department of Urban Studies
Queens College, C.U.N.Y.
Flushing, New York

Ms. Sidel's paper helps us to understand something about the role women workers have in the U.S. health system. The two systems are very different, the one reflecting the communist philosophy of serving the masses, the other reflecting the capitalist philosophy of monopoly control and profitmaking. Nevertheless, both systems depend to a large extent on women workers, and both have had in the past and still have an attitude toward women as primarily childbearers and husband-servers, and as inferior human beings. Why then the new roles for women health workers in China?

We first have to speak of women in general in China. The liberation of women from oppression within the family was and is a key point in the Chinese revolution. Thus, the Chinese leaders have made a point of creating new roles for women in the labor force in general and in the health care system in particular. In China we find both men and women working in the same occupations and at all levels of the health system, whereas in the U.S. women are channelled into nursing and allied health professions, with medicine and hospital administration reserved for men. The different attitude toward women can be seen in the support for maternal and infant care, which China has made a high priority. A philosophy of serving the masses requires serving women, who are half the masses, and children, who are the future masses. In the U.S., in contrast, the health system pays little attention to such low-prestige people. Women patients are often considered to be hysterics or hypochondriacs, and the lack of concern for women as childbearers has resulted in maternal and infant death rates that are an internationally known disgrace. Sixteen industrialized countries have lower maternal and infant death rates than the United States. Thus we can see that government policies toward sexism affect women both as patients and as workers.

I am not advocating China as a feminist paradise. They have come a long way, but they still have a long way to go, as they themselves understand. At least they are on the road.

Ms. Sidel's paper is called new *roles* for women in health care delivery and it is on *roles* that I want to concentrate. By role I mean what they do every day, who they do it with, who they do it for, what is their position in relation to other people. It is important to keep in mind that we are talking about relatively low level workers and about women. What they do is not what the U.S. medical system lets its lower level workers do, or what the U.S. system lets mere women do.

In China, hundreds of thousands of women have *direct, independent, decisionmaking responsibility* for public health, patient care and community action. Of the millions of American women working in the health service industry, how many have a position like that?

I think it is useful to look at the Chinese worker's relations to her patients and her superiors. The barefoot doctor, Red Medical Worker, midwife, and worker-doctor are doing actual patient care—diagnosing, prescribing, delivering babies, giving immunizations, deciding who needs what, making decisions for the good of the community; all independent of the control of a physician. Her contact with clinics and hospitals and doctors is limited to a few days a month plus consultations. The local health clinic is part of the community. The health worker spends most of her time in the company of people who are not health workers. She works in the community, with the community, for the community.

What a contrast to our own system, in which most workers, including most women workers, work inside hospitals under strict bureaucratic control. Although the women may *do* most of the work, the doctors and hospital administrators have control over the work, make the decisions, tell other workers what to do. The role of most women in the American medical system, even women in supervisory capacities, is to work *for* the bureaucracy, for the doctors and the hospitals. Most workers' primary task is to serve the needs of the doctors and hospitals, and only secondarily to serve the needs of the patients. The bureaucratic superiors not only control the subordinate workers but also control the interaction of the patients with the workers. Although most women in health service see themselves as helping patients, and went into health work for that purpose, the actual decisions they can make and the actions they can take are controlled from above. They

are taught in training programs and on the job that they should not take independent action, they should not make decisions, they should not challenge their superiors. In short, they should know their place. In China she is urged to learn as much as she can and do as much as she can, for her constituency and for her patients, not for her superiors.

Whether the U.S. hospital worker will keep her job, or will be given one of the few promotions available within her occupation, depends on how satisfied her superiors are with her service. In China her future depends on how well she serves her patients, and her patients decide through the community elections. This difference is not merely because the United States medical establishment thinks women are not capable of making decisions. In a fee for service industry, where
114 the money is made from treating patients, it is important for the doctors and hospitals to keep control over the patients in order to get the money. Lower level workers are not seen as resources to improve the nation's health, but as cheap labor to improve profits and income. One reason you find women concentrated in highly skilled but very poorly paid health positions is that the men at the top see women as cheap labor, as docile labor which will stay in its place.

Since physicians have risen to their prosperity and eminence by adopting the model of monopoly control and keeping other people off their income-producing territory, other occupational groups have followed the model. At each level of the occupational hierarchy, the licensure and professional certification system limit the training of still lower level workers and forbid them to use their skills. The regulations have the effect of suppressing competition and creating barriers to upward mobility, and of keeping the subordinates' wages down while the higher level occupation tries to expand its territory and raise its income. New occupations are created to maintain the status quo. When nurse-practitioners began moving to fill the gaps in service left by physicians, the medical profession developed the occupation of physician assistant to keep nurses in their place.

The division of laborers is bad for people's health. I have already referred to the U.S. maternal and infant death rates. Few doctors, and fewer obstetricians, are interested in providing prenatal and obstetrical care to inner-city or rural women who cannot afford high priced deliveries. Nevertheless, organized medicine campaigned to destroy traditional midwifery several decades ago, and has worked to halt the spread of nurse-midwifery service which can provide the desperately needed care. Nurse-midwives are competition, and organized medicine prefers a monopoly. Meanwhile, mothers and babies are dying.

The abolition of the profit motive is not the only reason the Chinese system works better. Some countries with socialized medicine show hierarchical competition similar to the U.S. Rather, the difference is whether the work is controlled from above or controlled from below. Control from above means that the superiors keep their jobs and/or their incomes by keeping both patients and workers dependent on them and getting the subordinate workers to do the dull routine work. Only when the community has a measure of control—which it has in China since the barefoot doctors and medical workers get paid by their communities—then the emphasis will be on getting the job done by whatever means necessary, by whoever can do it, and to hell with the hierarchy.

What else do Chinese health worker's do? She is supposed to mobilize the community to take care of itself and to protect itself against diseases. Part of her job is to stir up trouble—to lead public campaigns, create community outrage, mobilize against health hazards, lead reform movements. In this country we also have campaigns against health hazards—such as lead paint poisoning, black lung disease, automobile injury, industrial pollution. The people who lead such campaigns are called troublemakers. Women who lead such campaigns are called worse than that.

Another part of the Chinese health worker's role is to educate the community, so that people know what to do and why, how to take care of themselves and be independent of the health system. In the U.S., ignorance keeps people dependent on medical treatment. Since public health is not public information, more people get sick than need to. Since they are not taught how to treat themselves they have to go to doctors, even for minor matters that a lower level health worker could take care of. Going to the doctor will not necessarily do us any good—about one-fourth of all illnesses in this country are iatrogenic, that is, caused by medical treatment. (No wonder malpractice insurance is so expensive!)

The medical establishment seems to take the attitude that only they have the right to know and what we don't know won't hurt us. What we don't know will hurt us. Despite all that medical science knows about gynecology and obstetrics, feminists had to publish *Our Bodies, Our Selves* in order to get knowledge about women to women, who are most certainly the people with the right to know. Physicians, researchers and government agencies told us little about the dangers of birth control pills. Feminists had to investigate on their own and tell us.

All this treatment and mistreatment is very costly to us—it is costly in terms of our health, and costly in terms of our pocketbooks, whether we are paying for it individually, or as part of a group insurance plan, or out of our tax dollars. The money to support the medical system comes from the patient and the public, whatever route it takes to get there.

In China, by contrast, the medical worker's job is to keep people away from doctors. The medical worker is urged to learn as much as she can, do as much as she can, and teach people to do as much for themselves as they can.

Now I want to consider some of the things women health workers can do about the U.S. medical system. Since I have said that the health system derives from the

political philosophy of the greater society, the logical conclusion is that we need a revolution like China's. However, I think it is fair to say that you do not *have* to be Chinese to favor good health care for the population. And if you wait for a revolution you will never get anything accomplished. There are elements in the American establishment that would support reforms; there are many organized efforts in the community to bring about change. Women health workers can and should join in the efforts.

Women health workers must challenge the current subordination of women workers in health. Women are not cheap, docile labor to do other people's dirty work. Rather, women have skills and the right to use them. Women have a right to as much education and power as is needed to do the job, and the job is good health care for everyone. Nurses, allied health professionals and community health workers should press for more responsibility for diagnosing, prescribing and treating patients independent of physicians. I am not suggesting just more occupational competition, but rather that women join together, across occupations, in an effort to change licensure laws and professional certification in order to allow a larger number of the already available trained workers to give needed health services. Through unions and professional societies women workers have to press for more decisionmaking, better wages, and improved working conditions from hospitals.

Women health workers have to protect the rights of women as patients. It is hard as an individual to protect a patient from a doctor, since you may lose your job that way. But you can help organized women in the community fight bad medical practice by giving them information about particular doctors or hospitals which they cannot learn from the outside. Or you may join a collective effort of calling for health law reforms or changes in hospital policies.

As citizens as well as workers, women must join efforts to reform the structure of the system, putting more resources and attention into preventive health, public education, and campaigns against bad health conditions. Feminists in the community need the help of women in the health system. Particularly in the current depression we cannot afford to let people get sick for lack of concern and then pay outrageous prices to doctors, hospitals and health insurance companies to cure them. Another step would be the decentralization of health care into free-standing community clinics and independent public health stations with responsibility for maintaining general health.

Health should belong to the people and not to the doctors and bureaucrats. Feminists and other community activists are working in a variety of ways to liberate people from the medical system. We must all join together to accomplish our goals.

The Chinese say that women hold up half the sky. Let it never be said that the sky fell because we did not do our part of the job.

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New Roles for Women in Health Care Delivery A U.S. Response to Conditions in China

The Women's Health Movement: Political, Social and Working Roles For Women in Health Care Delivery

Helen I. Marieskind, M.P.H.

Assistant Professor of Health Sciences
State University of New York
College of Old Westbury
Old Westbury, New York

Just as China has improved her health status and services by utilizing the resources of her people for solutions, so too are thousands of women in the U.S.A. today pooling our resources in a similar process to obtain quality health care for ourselves.

We have joined together in a co-operative endeavor identified as the Women's Health Movement.[1]

Originating from abortion law reform groups and consciousness-raising sessions formed through the Women's Liberation Movement, the Women's Health Movement strives to achieve its goal of quality health care for women by conducting health education programs, by organizing to change institutional practices and by providing alternate health services for women.[2]

I intend to focus on these alternate services in this paper because they provide the clearest example of the ideology, the practice, and the political nature of the Women's Health Movement, as well as demonstrating a viable alternative to the current delivery patterns of women's health care in the U.S.A.

In her paper Ruth Sidel quotes from the Third Kwantung Provincial Women's Congress and cites their recognition of the importance of combatting the inferiority complex which haunted women into the new society.[3] In the Women's Health Movement we too are acutely aware of the need to erase this sense of inferiority as a prerequisite to providing quality health care for women. In America we are taught as women that we are basically untrustworthy, that we are not clever, good for only household chores. We are taught to be passive and subservient, then criticized for not being ambitious and responsible. We are denied education and access to careers on the grounds that our biology renders us incompetent, and above all we have flawlessly moulded ideal images held up to us as "perfect" women.[4] This caricature of womanhood appears never to wrinkle, never to blemish, never to miss a PTA meeting, nor to menstruate, nor to experience pain in labor—nor to have any health problems at all. Measuring against this model, normal women find themselves miserably wanting; a sense of inferiority is established.

The medical profession and obstetrics and gynecology in particular, has been responsible for contributing to this sense of inferiority. In 1905 F. W. Van Dyke, President of the Oregon State Medical Society, claimed that: "hard study killed sexual desire in women, took away their beauty, brought on hysteria, neurasthenia, dyspepsia, astigmatism and dysmenorrhea". Educated women, he added, could not bear children with ease because study arrested the development of the pelvis at the same time it increased the size of the child's brain, and, therefore, its head. The result was extensive suffering in childbirth by educated women".[5]

Lest you think we have progressed since 1905, William J. Robinson warned in 1931 in his 22nd edition of *Women: Her Sex and Love Life:* "that only a minority of women [were] free from illness during their menstrual periods, and that most should rest at least two days, avoid dancing, cycling, riding, rowing, or any other athletic exercises, and probably postpone travel by auto, train, or carriage".[6]

And it was in 1970 that *Novak's Textbook of Gynecology* (despite Johnson and Masters) assured us and future generations of obstetrician-gynecologists that: "The frequency of intercourse depends entirely upon the male sex drive. . . . The bride should be advised to allow her husband's sex drive to set their pace and she should attempt to gear her satisfaction to his. If she finds after several months or years that this is not possible, she is advised to consult her physician as soon as she realizes there is a real problem".[7]

Menopause—the very normal function of all women was declared by Dr. Francis P. Rhoades, President of the American Geriatric Society in 1973 to be: "a chronic and incapacitating deficiency disease that leaves women with flabby breasts, wrinkled skin, fragile bones and a loss of ability to have or enjoy sex".[8]

These crippling examples of medical mythology are actively counteracted by the self-help groups which underlie the Women's Health Movement. Conceptualized in 1971 by Carol Downer of The Feminist Women's Health Center of Los Angeles, a self-help group is comprised of about eight women from diverse backgrounds who meet on a regular basis and share their medical and health experiences, including learning breasts and vaginal self-examination.[9] In this sup-

portive environment women free themselves of the medical and social standards which have declared them to be abnormal, sick, and incapable of making informed judgments. The increased confidence gained from these shared experiences enables women to develop their own identities and values. Women become sharply critical of a system which continues to keep them passive and subservient.

From these initial self-help groups, many women have organized health services where their insights and knowledge gained from their group experiences can be put into mdical practice. There are approximately fifty women's health clinics in the United States and over 1,100 women's health groups providing diverse services.[10]

These clinics have been formed because of the lack
118 of preventive care provided by professional medicine, by the lack of primary care including obtaining such simple necessities as pap smears and breast checks, and to provide an alternative to the all too frequently degrading and humiliating experience of the male doctor-female patient encounter.

A typical women's clinic offers routine gynecologic care—pap tests, breast examinations, treatment and education to prevent minor vaginal infections—contraceptive services, abortion care, and maintains a referral service for more complex needs. A few clinics offer basic primary care. Self-help groups are part of a clinic's outreach program and may be organized around such topics as breast cancer, hysterectomy, menopause, childbirth or for young women—puberty.

In breast cancer groups for example, women learn the alternative operative procedures available to them, the importance of breast self-examination is stressed, and much needed support is offered to the woman who is a breast cancer patient.[12]

Clinics are generally staffed by lay women health workers who function to provide all the routine services, and a physician who performs the medical responsibilities defined by law. Many clinics seek to include nurse-practitioners on their staff and to encourage their clients to utilize midwives, recognizing the superior infant and maternal mortality records enjoyed by countries in which midwifery is widely accepted.[13]

In recognizing the importance of preventive care, the Women's Health Movement has begun to consider the appropriateness of the specialty of obstetrics and gynecology itself as the optimal medium through which women can obtain their health care.[14]

In evaluating the field we must realize that it is not merely the socialization, training, practices, and content of obstetrics and gynecology which oppress women, but that by structuring such a reproductively specialty, the medical system reinforces the wider social ideology which views women as sex objects and reproductive organs. The medical model reinforces women's socialization that their identity lies in their reproductive potential and it is through this potential, essentially through their reproductive organs, that women enter the health care system. This is true also in the public sector where women as reproductive organs receive care through a maternal and child health classification.

I allow there have been some advantages to being reproductive organs in the eyes of the medical profession and to those funding public health programs. Millions of women have received prenatal and contraceptive care and thereby an entree, however temporary, into the medical care system. Considering the socioeconomic and political status of most of the world's women, even such a fleeting glimpse at medicine would have been denied them had they not had a uterus and a vagina.

But let's consider what that entree has meant and whether those advantages outweight the disadvantages. Women experience the frustration and indignity through maternal and child health projects of receiving fragmented obstetrical care for about ten to eighteen months at best, then are dropped from the system because they return to being women, not reproducers.[15]

Women find that public monies are readily available for contraception, but once enticed into the health system they find that any other health need is not part of the government grant.[16] As our Third World sisters have bitterly discovered, sterilization seems to be the most "accessible" form of contraception offered.[17] Women may enter the system for cervical cancer screening only to find that breasts examinations are not included or at best are available in three months.[18]

In the private sector we seek gynecologists for our health needs because we have been socialized to think of them as our primary providers; indeed the American Association of Obstetricians and Gynecologists reported in 1974 that eighty-six per cent of women in their study saw no physician other than a ob-gyn on a regular periodic basis.[19] This they claim, as does the A.M.A., means that obstetrician-gynecologists should be formally recognized as women's primary providers. Yet as women consumers, we know that we do not receive primary care from gynecologists: on the contrary we find a physical is a pelvic examination and possibly a breast check. What of eyes, ears, lungs, hearts, etc? [20]

We are not dying from the maternal health conditions which used to kill us and which were more appropriately treated in an obstetric-gynecologic classification. We are dying from old age, from strokes, from chronic diseases and from cancer, but even here lung cancer has already replaced uterine cancer as the third leading cause of cancer death in women.[21] Fewer and fewer of us are having babies [22] and we are widely using systemic contraceptives rather than localized techniques.[23]

The endocrinological effects of contraceptives are of grave concern to feminists,[24] and even more so when we find in a 1972 study published by Dr. Michael Newton of the American College of Obstetricians and Gynecologists, that the majority of newly graduated gynecologists themselves rated their training in endocrinology as "poor" and their preparation in cancer re-

search as ranging from "satisfactory" to "poor". Half of those surveyed rated their training in basic science courses as "lacking", but the majority called their schooling and their hospitals' services in surgery as "excellent".[25] Perhaps right here lies one major explanation for the excessive rate of pelvic and breast surgery in the U.S.A.[26 27 28 29]—it is the only thing the gynecologist is well-trained to do.

Under present training programs then it is farcical to define the gynecologist and his specialty as primary care despite the frequency with which he is used by the majority of the female population in this country. Recent Congressional legislation excludes the gynecologist from this definition[30] despite the August 1974 decision by the Department of Health, Education, and Welfare to recognize ob-gyn as a primary care discipline.[31] The A.M.A. supports primary care status for the specialty but writes that the decision of the American Board of Obstetrics and Gynecology to reinstitute a basic "foundation year" before the three years of formal training "indicates that the specialty has recognized that the obstetrician and gynecologist must be further trained as a *primary physician* to diagnose, treat, or refer the many patients with diseases not traditionally in the purview of obstetrics and gynecology."[32] I contend that a basic "foundation year" is inadequate to turn an ob-gyn into a primary care physician. I suggest that we disband the specialty of obstetrics and gynecology, that the care of women be returned to midwives and to internists trained in primary care, and that we reserve for extreme necessities, surgeons with gynecologic experience. In this we would recognize the true origins and functions of the obstetrician-gynecologist.[33]

Clearly to utilize primary care internists for women's basic health needs would present immediate personnel problems. We might advantageously copy the Soviet model of an *Akusherka*, an obstetric health worker, who in conjunction with primary care physicians and gynecologic nurses provides routine preventive health care for women in polyclinics in the U.S.S.R.[34] Such a health care delivery paradigm avoids fragmenting the individual woman and contains the advantages of providing total health care to complete persons, not gynecologic care for reproductive organs. Yet the practitioner is relieved of the simple tasks which can be capably handled by others and most probably more effectively handled by them in terms of teaching preventive health practices.

Providing alternatives to the traditional doctor-patient model is not in itself a new concept in the U.S.A., nor even in gynecology. In his inaugural address upon installation as President of the American College of Obstetricians and Gynecologists in 1970, J. Robert Willson said that: "in large measure physicians' training is wasted upon the performance of routine health-care functions". These functions should be given, he said, "to non-physician associates, who, with a lower level of training, could perform them very well, thus freeing the fully educated and trained physician for more serious problems, which require the exercise of true medical judgement and skills."[35]

Similarly Drs. John Marshall and Donald Ostergard of Los Angeles County's Harbor General Hospital have developed a gynecologic health worker known as a women's health care specialist. Women with non-medical backgrounds are given a six-month training period by physicians and then perform routine gynecologic tasks under physician guidance within clinic settings. They treat minor infections, detect and refer major illnesses, and in many cases insert intra-uterine devices.[36]

Midwives too must be seen as yet—most regrettably in my opinion—as an alternate service. Generally located in large county or municipal hospitals, midwives are slowly gaining acceptance in hospital-based deliveries.[37] If we are to learn anything from the health experiences of other countries it is to know the value of the nurse-midwife and to integrate her into our mainstream medicine.[38]

What then is new about the alternatives proposed by the Women's Health Movement? Their uniqueness lies in the process of health care delivery, in the destratification of all health workers, and the subsequent change produced in the social and healing relationships of providers and patients. Women health workers in women's clinics learn the skills of the paraprofessional and see themselves as peers of their patients, not setting themselves apart with the airs of professionals. In this lies their greatest similarity to the Chinese experience.

In a women's health clinic all health workers are on a par. Physicians merely have certain utilizable skills derived from extensive and elaborate training. Workers are integrated equally into the structure, process and outcome of health care delivery and may exchange functions to better appreciate each other's responsibilities. From these exchanges the Women's Health Movement understands that the current training programs which divide one class of health personnel from another ultimately serve to defeat the production of quality health care and to hinder the patient in the healing process.[39]

In breaking down the hierarchical medical structure in its clinics, the Women's Health Movement has also changed the process of medical care delivery. For example, attempts are made to completely redefine the patient and provider roles and subsequently the relationships which normally arise from these roles. Women in feminist clinics are not passive bystanders to their medical treatment, nor the objects of care, rather they are active participants. The patient is not the recipient of the commodity of health care but is a co-producer in the health care process. For example, a woman coming into a women's clinic for pregnancy screening will not sit passively awaiting the results, she will participate in the procedure, deciding for herself according to the guidelines provided whether she is indeed pregnant or not.

Even greater participatory roles for consumers are

being pioneered through the Feminist Women's Health Centers. Consumers experience care as a collective, discussing their histories, learning to examine each other, and sharing their experiences. The consumers themselves provide the significant healing relationships and the role of the health "provider" becomes that of a mere facilitator. Good health is seen as a collective endeavour growing out of the group's experience of health and disease, their sense of well-being and discomfort. The subjective experiences of the consumers are valued, and the social and medical stereotypes which have been barriers to rigorous scientific exploration are pushed aside. In these settings patients are people, and they are autonomous, empowered people.[40]

It is this change in social relationships—fundamental to the women's alternate clinics originating from the self-help groups—which best identifies links between the Chinese health system and the Women's Health Movement. And it is this aspect of Chinese health care, fundamental to understanding Chinese society, which is most frequently overlooked by observers. To quote Joshua Horne: "I think that China has made more progress in transforming human relationships than any country in the world and the relationships which are developing in Chinese hospitals illustrate the direction of change. The relationship between patients and doctors in China is based on equality and mutual respect. If both are contributing to the building of socialism, their differing contributions represent a division of labor in a common cause. There is no room for a superior or patronizing attitude on the part of the doctor and neither is there any room for the bluff heartiness, false familiarity or any other of the devices which often masquerade as a bedside manner".[41]

In the Women's Health Movement we too are devoted to transforming human relationships. We have learned through our clinics that it *is* possible, and we are heartened by the Chinese experience to know that those relationships can be extended to society as a whole. We recognize that a health system is a reflection of the goals and political values of a social system and we believe that by changing the values, the goals, the social relationships within *our* health care system, we are providing a blueprint for social change in the fullest sense. We are building a new society and we are building it together as women freed from a sense of inferiority, freed from a role of subservience taught by the old society and reinforced by the medical profession. In that knowledge lies our revolutionary strength.

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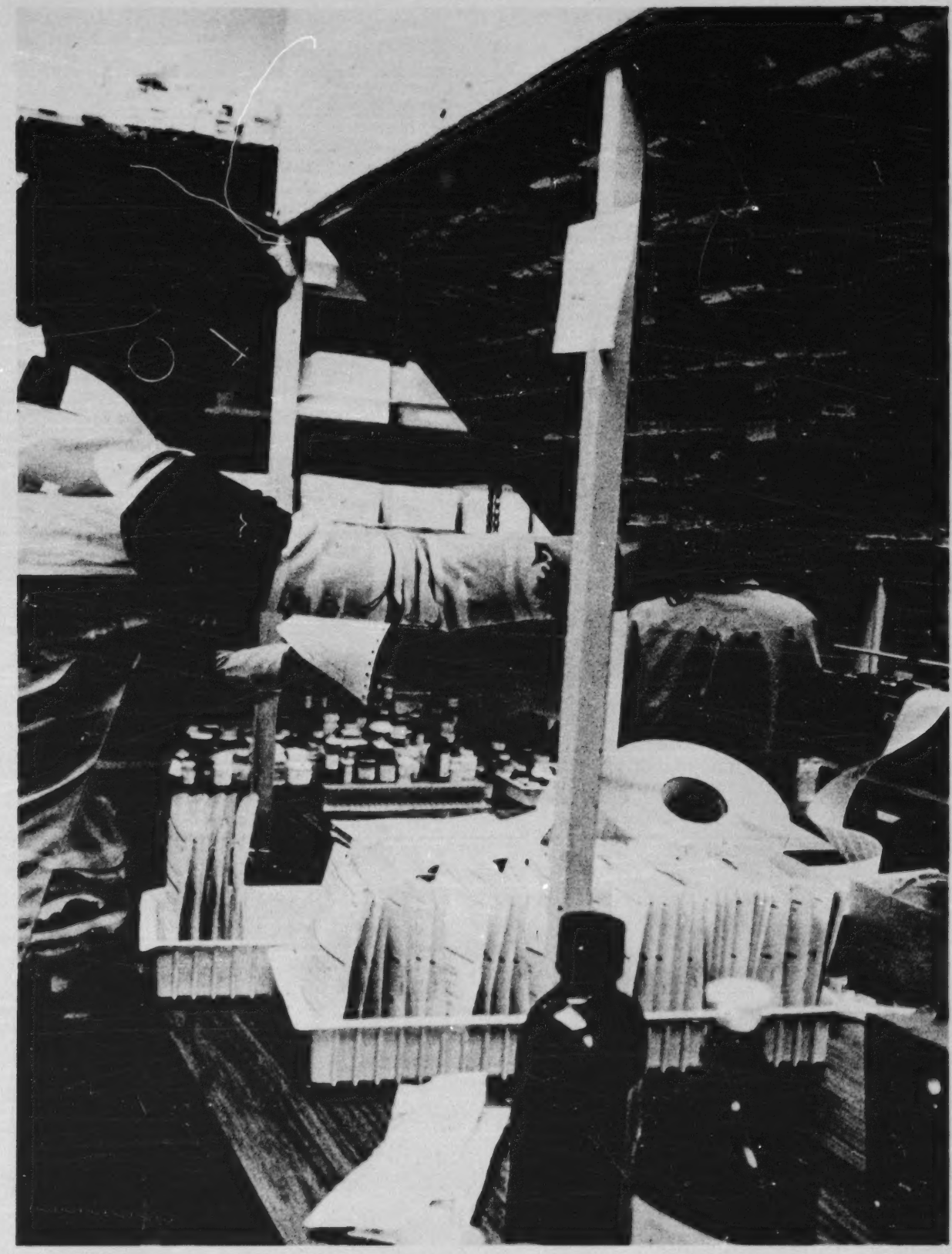

New Roles for Women in Health Care Delivery
The Cameroonian Experience

Utilisation of Women in Health Care Delivery in Cameroon and Africa

Gladys E. Martin, M.D., M.P.H.
Associate Professor in Community Medicine and Pediatrics
University Centre for Health Sciences
Yaounde
Cameroon

Africa is a large continent made up of several countries at different levels of development. There are two major religions—Islam and Christianity, and paganism. Certain factors,[1] closely related, determine the health status of each nation. These factors are environmental, socioeconomic, sociocultural, religious and educational. Demographic data are similar, thus we have high morbidity from preventable diseases such as malaria, measles, gastroenteritis and filiarisis. We have very high mortality, especially in children and pregnant women also from preventable causes already mentioned and complications of pregnancy. Nutrition, gastroenteritis and intestinal parasitosis are disease entities in their own right but are underlying causes of severe illness and death. Figures given by the World Health Organization[2] are a birth rate of 45 to 50 per 1000 population; neonatal mortality 50 to 58 per 1000 live births; infant mortality of 100 to 200 per 1000 live births; mortality under 5 years of age 150 to 300 per 1000; crude death rate of 25 per 1000 and maternal mortality of 5 to 10 per 1000. These rates are several times those of the developed countries.

For any health care system to have any impact on these problems we need a health infrastructure, trained personnel, money and several years to achieve good results.

Money is inadequate, with several African countries spending between 2 and 5 percent of the National Budget[3], on health, i.e. about $0.50 to $1.50 per capita compared to the U.S. figure of $242 per capita. Well trained personnel are few and maldistributed between rural and urban areas. Most of the well trained personnel are in the urban areas where only 20 to 30 percent of the population live. In 1971 the ratio[3] of trained personnel per population given by the WHO[2] was one doctor to 17,500 inhabitants; one nurse to 6000, one midwife to 17,000; and one sanitary engineer to 2,370,000.

Cameroon

Cameroon is situated along the Western coast of Central Africa bordered on the East by the Central African Republic and Gabon, and on the West by Nigeria. It lies within latitude 3° and 12° North of the Equator. The physical features vary from equatorial forest along the coast, through grassland on plateaux to scrub and semi-desert in the North. It is divided into seven administrative provinces and its culture is derived from France and Britain as well as the indigenous ethnic culture. The surface area is 564,000 km^2[4] with a population of 5.8 million in 1970, an average density of 12.5km^2 (range 2.5-71.9) and an annual growth rate of 2.1 percent. The women:men ratio is 51:49. The economy is mainly agricultural with a per capita income increasing at a rate of 4 percent per annum. In 1960 it was 21,000 francs CFA (approx. US$ 100). The health personnel to inhabitant ratios are: one doctor to 22,000, one nurse to 9,000, and one sanitary engineer to about 6 million.

Trained Health Personnel

There are 323 doctors of whom 153 are Cameroonian and only 12* are women. The first Cameroonian woman doctor qualified in 1962. Some women doctors are working in other countries because of marriage. All these women doctors in the country are fully employed. Most are in charge of maternal and child health centres. There is no woman doctor involved solely in the Central Administration but their contributions are sought during planning. The University Centre for Health Sciences[5] was opened to medical students in 1969. Two of the 37 students are females and we are looking forward to their graduation, along with their male colleagues, in September 1975 as the first batch of Cameroon-trained doctors. Of a total of 248 students, 34 are females, a percentage of 13.7. This percentage is high compared to other countries and on the whole the trend is one of increase: in 1969 the ratio was one female to 15 males, and by 1973, the ratio was one female to eight males. They all receive the same training and hardship both in the campus and in field projects. It is even harder on some of those who are combining motherhood, housewifery and medical studies.

*Of the 12, 5 are Cameroonians, 4 by marriage and 3 expatriates.

State Registered Nurses and Midwives

Women nurses are very much in the majority but men are trying to get in. There are three training schools in the country where they are prepared to occupy jobs at the "B" Category (State Diploma) with opportunities to advance. Post-basic training is recognised and a regional centre for training nurses in administrative and teaching roles is being run under the auspices of the WHO but as a section of the University Centre for Health Sciences (UCHS). In this section there are nine male and five female Cameroonians.

Two lower categories of nurses are trained—"Brevete" and nursing aids—and these trainings are done in special schools. Periodically, exams are held to allow these nurses to move into a higher category with better pay and more responsibility.

"Matrons" and "Journalieres"

These are people without the regular education and at a slightly older age, employed and trained on the job. They undertake minor unskilled jobs like cleaning and serving food. Some are taught routine things like weighing. They also may take exams into nursing aid schools for more training and promotion.

Changing Role of Nurses

Because of the shortage of doctors, nurses and midwives do much more than they are expected to do. A nurse in charge of a health centre does consultations, routine minor operations like herniorrhaphy, circumcisions, etc., and in emergencies laparotomies. In midwifery they conduct forceps and vacuum extraction and other complications of pregnancy. In some places these extra skills and knowledge are acquired on the job through watching and assisting doctors. In other circumstances this extra duty and responsibility passed on to the nurse is recognised and they are given special training. In Ethiopia midwives in some maternities are officially taught and expected to do forceps and vacuum deliveries.

Being taught more theory and skills is being recognised as a way of decreasing the doctors' workload and offering better service to patients, thus we have several names such as nurse practitioners, family health nurse, etc., as in the United States. Nurses and midwives now run maternal and child health [6] clinics preventing disease and promoting health while at the same time treating our common problems—feeding, diarrhea, vomiting, and fevers. They are also involved in family planning (not in Cameroon). In Africa, nurses had performed this role unofficially but they are now being recognised for their higher skills. The other usual roles for women in health such as physiotherapy, occupational therapy and laboratory technology, are not yet popular in Cameroon but with modern hospitals and health centres the need for these services will be felt and met.

Role of Women in the New Health Occupations in Africa

A lot is happening in the developed countries to medical science. Advance in technology is moving patients away from human contact to be "monitored" by machines. Therefore, more people are looking for alternative jobs. In Africa most of our problems are basic to our environment, our socioeconomy and culture, and to our illiteracy. Our health problems cannot be solved without solving these other problems, thus the emphasis has changed. We think of the people in their families and communities and how to improve their living conditions. By giving them clean water, clean environment, balanced food to eat we would cut down on our morbidity. By giving them simple lessons on hygiene, child care, and causes of disease, the impact on mortality and morbidity will be greater still. Then by teaching them to help themselves solve their problems, earn more money, we would have created an atmosphere for human development, progress and continuity.

Most of the people who need help live in the rural areas (70 to 85 percent) and most of them are women. It is not possible to get nurses and doctors into these areas in the near future to bring about this change. We therefore, need a new type of people, usually women, to undertake this great task.

Community Development and Women's Programmes

The emphasis in Africa is on community development by the people with help and supervision from volunteers (internal and foreign) and governments (national and international). These development programmes go by several names: co-operatives, credit unions, welfare associations etc. For the International Women's Year a Women's Programme [7] has been formed as a unit of the Economic Commission for Africa (ECA) in the Human Resources Development Division and it is to ensure a "Progressive and meaningful participation by African women from all walks of life in the countries' development". One of its objectives is to form a Pan African Women's Task Force made up of volunteers in nutrition, health, home economics, crafts, etc. "to consolidate efforts of individuals and small groups". From 1975 to 1979 they will work with the United Nations Volunteers Program offering their special skills.

Community Development Women's Service in Cameroon [8]

I have been working in a suburban-rural community for about two and a half years teaching medical and nursing students the practice of family and community medicine. In order to teach students we must offer services to the inhabitants and they included a heavy load of curative care for preventable diseases at the onset, but now we are getting an increasing number of children and pregnant women seeking preventive services. Under-nutrition is a problem and we

are telling the people what to do about it. During visits to the villages it is obvious to us that unless something happens in the people (motivation to change) and then in the communiy, most of our efforts are in vain and we only increase our labours because we sensitize the people to their illness who in turn seek only drugs. We then decided to form village health committees [9] which must include at least one woman in each. By working with them at the village level we are seeing some changes. If we ask people to eat better food, should doctors and nurses talk about how to grow them? We need a team—a multi-disciplinary team to work with the people to improve their standard of living and their health.

The Community Development Women's programme was started in the former West Cameroon which is now two provinces—North West and South West. Studies are being carried out to introduce this programme to the other provinces. It is one of the three main services in the Department of Community Development [10] which falls under the Ministry of Territorial Administration. It is usual for health workers to be under the Ministry of Health but if health is regarded in its broadest sense the women in this service are offering a lot more, I may say, than hospitals to promote health in rural families.

This programme was started in 1953 by Miss O'Kelly, an expatriate Officer from the United Kingdom in the Ministry of Education. It started in Banso, North West Province. Women were encouraged to group themselves together, purchase a corn grinding mill thus saving time and energy grinding corn with two stones—one large and flat and the other oblong. When they gathered to grind corn they were taught hygiene, child care, housecraft, cookery and how to read. The cornmill societies grew in numbers and spread to several divisions of the now North and South West Provinces. Corn is not ground by women in all the provinces. It is the staple food in the northern parts of the country. Women were encouraged to get together thus in church groups and choirs, tribal and age groups and small units of the political party (cells) made up groups with which the Community Development Workers worked. The groups ranged from 15 to 20 members to larger groups of 40 to 60 members. It was recommended that the workers were not to initiate new groups but to use preformed groups by the women themselves. The workers gave lecturers, demonstrations and held discussions both at the meetings and in individual homes. Emphasis was on stimulating initiative and leadership so that there would be continuity within groups and extension.

In 1963 Dutch Volunteers came to Cameroon to assist with agriculture. The female members among them worked with the women, teaching knitting, sewing and other home crafts. The doctor and nurse in the group organized infant clinics and together they drew up an educational programme. Mrs. Lindsay (a Cameroonian now dead) was in charge of the cornmill societies and in 1965 merged the Dutch Volunteers with the cornmill societies in the Ministry of Education. A commission [10] from the ECA in 1967, recommended that the Women's Programme be a part of the Community Development Programme.

The general objectives of these combined Programmes are: "Helping women to understand group work and social change for the general improvement of living standards in homes, families and communities; encouraging self-help and self-reliance on the part of women; and training voluntary leaders to offer continuity to the programme of activities".[8]

Specific objectives are: Nutrition and cookery; various aspects of pregnancy, child development and child care; hygiene and sanitation including causes of diseases and ways to prevent them; care and improvement of homes; and other topics to improve their economy such as sewing and needlework, improved farming, savings. 125

Organization and Staff: The Director of Community Development is in charge of the Women's Programme at the national level. This post is filled by a man. Chief of Service, Women, is the head of the Women's Programme at the provincial level and she coordinates, directs the field programmes and is responsible for policy and staff matters.

Organisers or Supervisors: These function at divisional level. They plan and supervise the work of the social assistant workers, organise divisional refresher courses, and write reports. They receive professional training at the Pan African Institute for Development and are employed directly by the national government. Because Cameroonians are few, some of these posts are filled by foreign volunteers. There were 12 supervisors in 1973 in the North and South West Provinces.

Social Development Assistants: They are young girls with 12 years of schooling, holding the General Certificate of Education London Ordinary Level. They are employed by local councils and given one year training at the Community Development training school, Kumba. Being chosen locally, trained and paid by their local council is a way of encouraging that they return to work in their villages after training.

Finance

This programme is financed by the Federal Government directly through the Community Development Programme, indirectly through local councils and by foreign aid, thus:

—the UNICEF supplies equipment, training materials and transport.

—the Netherlands Volunteer Organization provides personnel who work with Cameroonian counterparts on the supervisory level.

This programme is new. It started 21 years ago as cornmill societies in the Ministry of Education and in the last seven years has been in the Community Development Programme of the Ministry of Territorial Administration. It has met with several problems such as personnel; very few are sufficiently trained and experienced. Their work is made more difficult by lack of

transport, equipment, seasonal bad weather and inaccessible roads.

There is no doubt that these people will do a great deal to improve the health of the families in rural areas. It is too much to expect a young girl after 1 year of training to have enough background knowledge and skill to teach the rural women. We know that rural or community development requires a multi-disciplinary effort. Therefore, at some level it should be possible to bring together all the different experts to plan and execute the programme. Doctors and nurses should be invited, maybe at the divisional level, to assist in teaching both the supervisors and the social assistants as well as the women in their meetings. This is done usually during divisional refresher or health shows.

126 **Women's Wing of the Cameroon National Union**

While the infrastructure and health personnel are being developed, the government is encouraging preventive and promotive health services through the women's wing of our political party. The Vice Minister of Health is the President of the women's wing of the Party. Under her portfolio is the home economics or medico-social centres. In the cities and large towns they have centres in which women meet regularly and are taught handcraft, cookery, and nutrition. Clinics are held on a regular basis for pre-school children and pregnant women. Vaccinations, drugs, prenatal care and nutrition demonstrations are given. Services are offered by doctors, nurses, midwives, and social workers on the medical side and on the other side, teachers in home economics.

During the long holidays courses are held for teenage girls. Lessons are given in cookery and nutrition, sex education, personal and home hygiene and elementary child care. It is hoped that this will supply the more practical side of life and reinforce the more theoretic school subjects. They would also be more appreciative of things in their homes and more useful to their parents and in future make them better mothers and wives.

The Women's Programme of the Community Development Department participates actively in these centres and courses and also at the smallest units of the political party, i.e. cells.

Societal or Cultural Variables Influencing the Utilization of Women in Health

As mentioned earlier, health and school teaching are the oldest professions for women in Cameroon outside the home and farm. For several years women could only be nurses or second grade teachers because opportunities for higher education were limited. Boys were educated in preference to girls and it was considered a waste of money to educate a girl highly, as she would later spend her time in the home. Sometimes it created difficulties in securing a husband as it was felt that a highly educated girl was worth a higher bride price. Secondary education was not available in Cameroon (former West Cameroon) and in the 1930's only boys were allowed to go to Nigeria, France or other countries for education. Therefore, girls received only primary education and this was a handicap. In the forties, parents began to allow their daughters outside the country for further education, thus a few girls got into the University. In the former West Cameroon the first girls' secondary school was opened in 1956 and since then more schools including mixed schools at both secondary and post-secondary level have opened. The percentage of girls reaching universities at home and abroad is small but steadily increasing, and there are girls even in the newly opened engineering school.

Marriage and child bearing are highly thought of in Cameroon and parents expect their daughters to put their husbands and marriage first. Motherhood and a profession are not incompatible because of the following:

—Labour is still relatively cheap so both husband and wife can work and employ someone to housekeep and baby-sit.

—The extended family still exists and one can still get older or younger relatives to housekeep.

—Changes are occurring which make it more difficult to get such help. There are alternative jobs and schooling opportunities.

—Maternity leave is granted to pregnant women with a percentage of their pay four weeks before and ten weeks after delivery. Maternity benefits are also paid by the Social Security Service to workers or wives.

—Mothers are encouraged to breast-feed their babies for long periods by being allowed feeding time for 15 months. Also the working hours are favourable towards breast-feeding and housework.

—Students do not discontinue their studies because of marriage or pregnancy so that many more qualify than some years back.

Men have always been the head of the family and their authority is recognised. On the whole, however, wives if they want to work can work. With the rising cost of living and the standard set by the couple it is necessary for both to work. Nurses and doctors tend to work irregular hours and this may be a bit upsetting to the family routine. If handled well, there should be no problems.

I have already mentioned that no female doctor occupies a Central Administrative post. It may be that there are not too many and those present are more useful at their posts. There is a general lack of women in key administrative posts. The nearest they come is a deputy head. Could this be sex discrimination? The Vice Minister of Health and Social Welfare is the only woman in the Government. It is very significant that she is in health; she is married and a mother, and woman of childbearing age and children, a vulnerable group, form 52.5 percent of the population.

Conclusion

It could be said that the health of the family and nation is in the hands of women—the non-health pro-

fessional woman who feeds and cares for her family thus determining their health; 70 to 80 percent of the rural population is made up of women at risk of dying from the stresses and strains of pregnancy, childbirth and family rearing. They owe it to themselves to acquire the knowledge and skills necessary to maintain themselves in good health. The nurse and doctor have a big job of treating the sick but must also have a broader perspective of health at the village and family level. We need more of them and we need to utilize them fully.

Last but not least are those women volunteers, local and foreign, working with the community development workers to improve the standard of living and decrease disease. In Cameroon women have opportunities to work to promote health. The setup is there socially and politically to do our bit if not from the top administrative jobs. We can be heard and seen at the local level. These are all women in health. At the community level they all come together from different disciplines and need to be coordinated well to be effective. At this level national and international governments come together. Funds and transportation are limited and made more so because of the fact that funds are specific, objectives being tied to watertight jobs or titles. Things should be flexible at this level to fulfill the different aspects of the common objective of Community Development.

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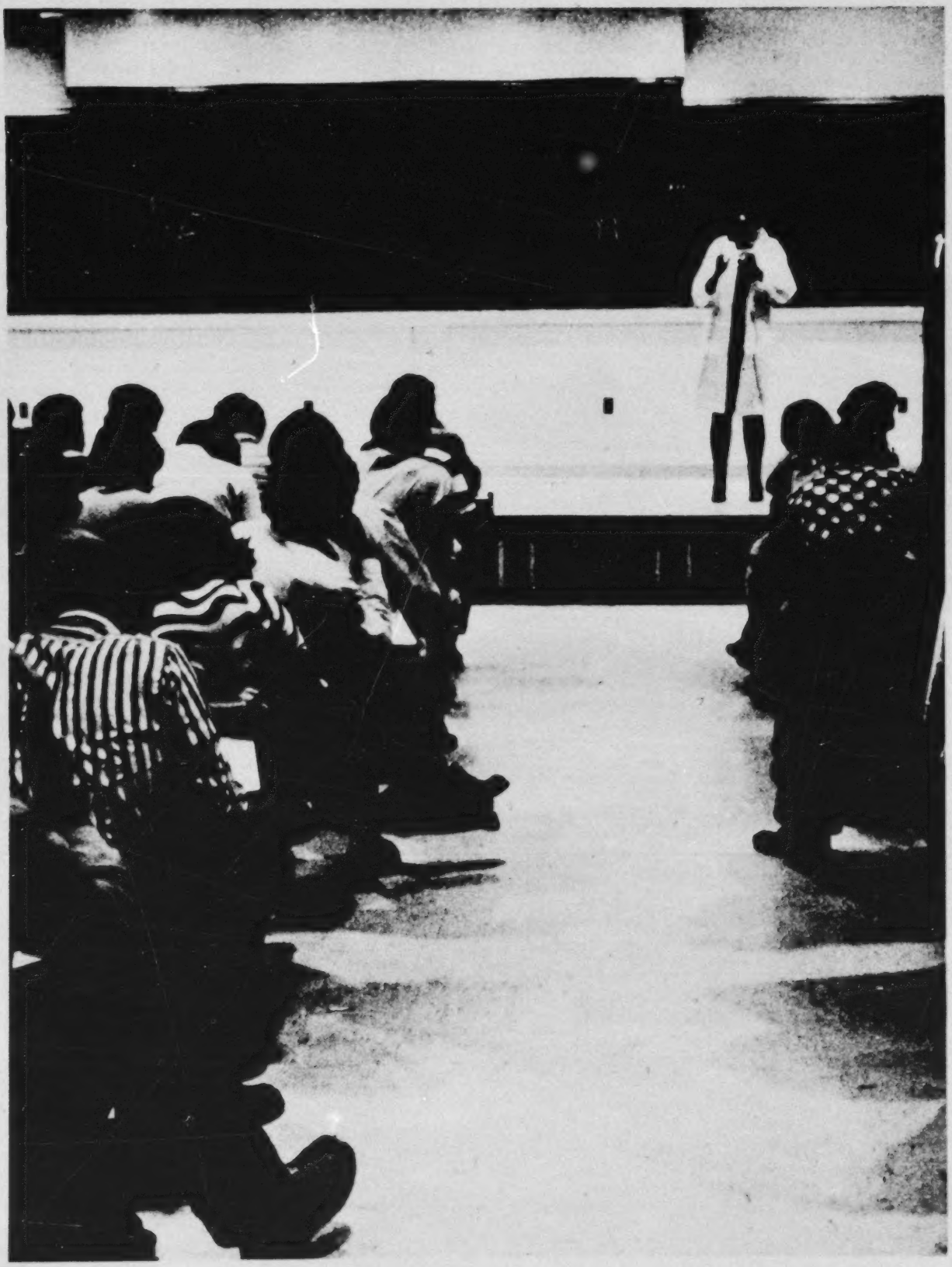

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New Roles for Women In Health Care Delivery

A U.S. Response to the Cameroon Experience

Mary Ann Lewis, R.N., M.S.
Director, UCLA PRIMEX
Family Nurse Practitioner Program
Los Angeles, California

The title of this presentation implies that change must occur if, indeed, new roles for women in health care are to exist. I should like to review briefly the past and present roles of women as providers and consumers of health care services. Then I shall present some data from studies we have conducted over the past four years that lead to some suggestions about how changes resulting in new and more appropriate roles for women could affect the outcomes of health care.

Past

In the past women as providers functioned primarily as nurses, educated outside the university, and employed in bureaucratic institutions. We served passively and dependently; we cared for rather than cured. We worked where and when assigned and our rewards were more intangible than economic. As patients women were viewed as passive and dependent, and frequently as hypochondriacs who sought care for problems most physicians labeled as trivial. The data on visitation rates *do* reveal that women are higher users than men. However, women are not greater users of care because they are more fragile.[1] And women, as a group, do not necessarily choose careers in nursing rather than medicine because they are intellectually inferior. The statistics describing women's behaviors as providers and consumers are primarily reflections of the images that exist in the minds of women and men as to the proper role of women in society.

Present

Currently, we're in a period of transition, although a painfully slow one. More women are being admitted to medical schools and an increasing number of nurses are seeking to expand their roles as nurse practitioners. This latter thrust is based in part upon a desire to escape from rigid bureaucratic settings where decision-making and rewards are limited. In these settings the only way to get promoted as a nurse is to move further and further away from direct patient care. It is also related to the pull of opportunities in these new roles to be actively engaged in assessing and managing the problems of patients and families. It provides an opportunity to be a colleague of the physician, rather than his handmaiden.

As patients, a small proportion of women have begun recently to demand care for themselves *as women*, rather than as patients with "female problems".

Future

And now, the future. As a practitioner I would like to prescribe some rather specific new roles for women in the future, both as providers and consumers. These changes must occur not just to further the cause of feminism, but also in order to improve the outcomes of health care services and subsequently the health of all of the people.

Despite an increased investment in health care, more personnel, more equipment, more beds, the end results or outcomes of care have remained relatively static. A significant proportion of our population continues to delay in seeking care (most of them are men).[2] About 10 to 15 percent without significant disease, who have been termed "the worried well", continue to use over half of all available ambulatory services (most of them are women).[3] And only about a third of the patients of both sexes comply with recommendations for treatment.[4]

The outcomes of health care will not change simply by placing women into more powerful roles as decision-makers—either as physicians or nurse practitioners or physician assistants. I say this on the assumption that the current model for educating these practitioners will prevail. In the traditional model the patient seeks help for a problem, is told what the problem is (perhaps not all too clearly), and then is given a therapeutic treatment plan to follow. While the patient has considerable responsibility in these transactions, she/he has very little authority—a very poor management strategy.

I suggest that if consumers continue to play a passive role in decisionmaking about their own care, their patterns of illness behavior will not change, and patients' compliance with treatment recommendations will continue to be poor. Remember the consumer's behavior, not the provider's, is in most cases, the primary determinant of the outcome of care.

Let us speculate about the consequences of sharing

the responsibility of care with the consumer. This involves allowing the patient to participate in decisions about options for solving the problem. It involves a transfer of power in the provider/patient interaction. It demands a fundamental change from the typical physician-dominant model for care that exists.

Nurse practitioners are currently making decisions about treatment, management, and are more cure-oriented. However, I believe it will be disastrous for us to replicate the authoritarian model exhibited by the medical profession. The outstanding contribution we have made as nurses has been *caring* for people who seek services for a variety of reasons. Because we were not equipped to cure people of their physical ailments we used the only trick in our bag—ourselves: we told our patients we cared; we would explore the
130 available community resources; would teach them about their (health) problem, and we would not desert them even when death approached. Now that we are learning something about "curing", we possess a powerful tool. It remains to be seen how we will use it, and if we, indeed, can improve the outcomes of care, not just through the use of our new-found power, but in the way we use it.

I became interested in the issue of patient-participation in care in 1966. As a public health nurse assigned to a health care team located next to a public school I had a 9-year-old boy come to me for a burn on his arm. He began referring other children to me, and before I knew it, I had a clientele of children seeking care on their own. This was a racially mixed community; there were many working and single parents. My observations suggested that over time these children (my patients) seemed to become more responsible and "something" was happening to them. This led to a search of the literature and a proposal to study self-initiated care for children. This resulted in a three year federally funded research project entitled Child-Initiated Care, just completed this past March. The purpose of this project was to involve children as active participants in their own health care rather than as passive participants in the usual provider/patient interaction, and to examine the effects, if any, of such a bizarre venture.

The first year of this study was spent in developing a conceptual model to describe the health-related beliefs and behaviors of children ages five through 12 years of age. For the past three years we have been operating a system in an elementary school with over 300 children in which they are free to initiate their own care by taking a "care-card" from a box in the classroom and go directly to the school nurse practitioner. The nature of the interaction between child and nurse was designed to give the child decision-making responsibilities regarding the management and disposition of the problem under specific rules designed to protect the child's health and welfare. For example, if a child presented with a stomach ache, the nurse would pursue the present illness, past medical history, do a physical examination, present the data to the child, formulate a problem list, and ask the child to generate options for coping with or solving her or his problem. The child then decides which option to choose. This interaction process was based upon concepts of social learning theory and a Rogerian orientation—i.e., the child *is* capable and competent to participate in this process.

The results have been quite striking. For example, manifestations of the sex-role behaviors ascribed to women and men appear very early in life. As early as second or third grade, girls see exposure of their body to the environment as more often productive of illness, in contrast to boys who cite overexertion or overeating. By age seven, girls more than boys believe care to be more essential. The patterns of utilization are similar for boys and girls ages five to twelve to adult males and females 20-45 years of age. Girls are found more often to be higher utilizers of care for nonmedical reasons, and the greater proportion of nonusers, those who never present themselves to the nurse's office for care, are boys.[5,6]

This work is continuing. The intervention has been demonstrated to have impact on behavior as well as certain elements of the theoretical model we developed.

While we must begin today with children to change tomorrow, we need not neglect women over the age of 12 years. An increasing number of women's clinics are appearing that focus on the problem of women and delivery of services in a way which is more consistent with the woman's view of herself. These services do not have to be limited to those who are actively associated with the women's rights movement. If nurse practitioners and physicians understand the issues related to the historical evolution of women's roles there is much that can be done for women patients in addition to the traditional model for care.

As an example, a few weeks ago I saw in a medicine clinic a 64-year-old woman whose chief complaint was rectal itching. She had received a very thorough competent medical work-up and was given an appropriate treatment regimen. However, she returned because she had not received relief. In seeing this woman I focused on two problems: 1) the nature of her physical problem and 2) the issues I saw for a woman whose home was being taken from her because it was part of a lien on a mortgage for a business that went bankrupt during the oil crisis. I confronted her with her feelings about this. She was angry at herself for not taking more initiative and refusing to allow her house to be taken from her. With regard to her physical complaint I asked if she had ever looked at her vaginal and rectal areas. She was embarrassed; no, she never had. I suggested that she take two mirrors and showed her how she could visualize the nature of the lesion. I learned to use this technique of self-examination with mirrors in our previous experience with children. I find that allowing children to wash their own cuts and examine in reducing anxiety and tears than verbal reassurance. themselves with a mirror usually is more effective

Summary

I am advocating major role changes for women as providers *and* consumers at all levels, i.e., home, school, health care facilities. This means that the subtle and not so subtle sex-typing that permeates society, and is reinforced in the media, i.e., that women are weak and need to take drug products to enhance their health status and sex appeal will have to be recognized for what it is—a commercial ploy exploiting and perpetuating these sex-role images. The continually reinforced concept that men are strong, domineering and invincible must also be re-examined in the light of sex-specific mortality rates.[7]

There is some evidence that the aggressiveness of males tends to make them more dominant in the interactions with others.[8] This quality may make it difficult for men providers to share power with patients. Perhaps this is another reason to encourage more women to become physicians and nurse practitioners, although I believe that without role models who will help them learn to provide care for patients as equals, and without a fundamental change in the balance of power between provider and consumer, this may indeed be a hallow victory.

Preparing women to be better providers of self care as a means of increasing access to care could be an international strategy. It is a means to achieve a sense of mastery and control over one's body and destiny. If women feel better about themselves, it might lead to a whole host of secondary gains for *all* members of society. The philosophy of the Cameroon Cornmill Societies is theoretically sound, as well as practical. Women provide the social glue for society. There are data to support the contention that the health and illness behavior of the members of family units is primarily related to the behavior of the woman in that unit.[9] If women the world over were given opportunities to learn to be better consumers and providers at all levels, then women's roles would truly be changed. And I believe that the greatest benefits of such changes would accrue to the more fragile or the species—man.[10]

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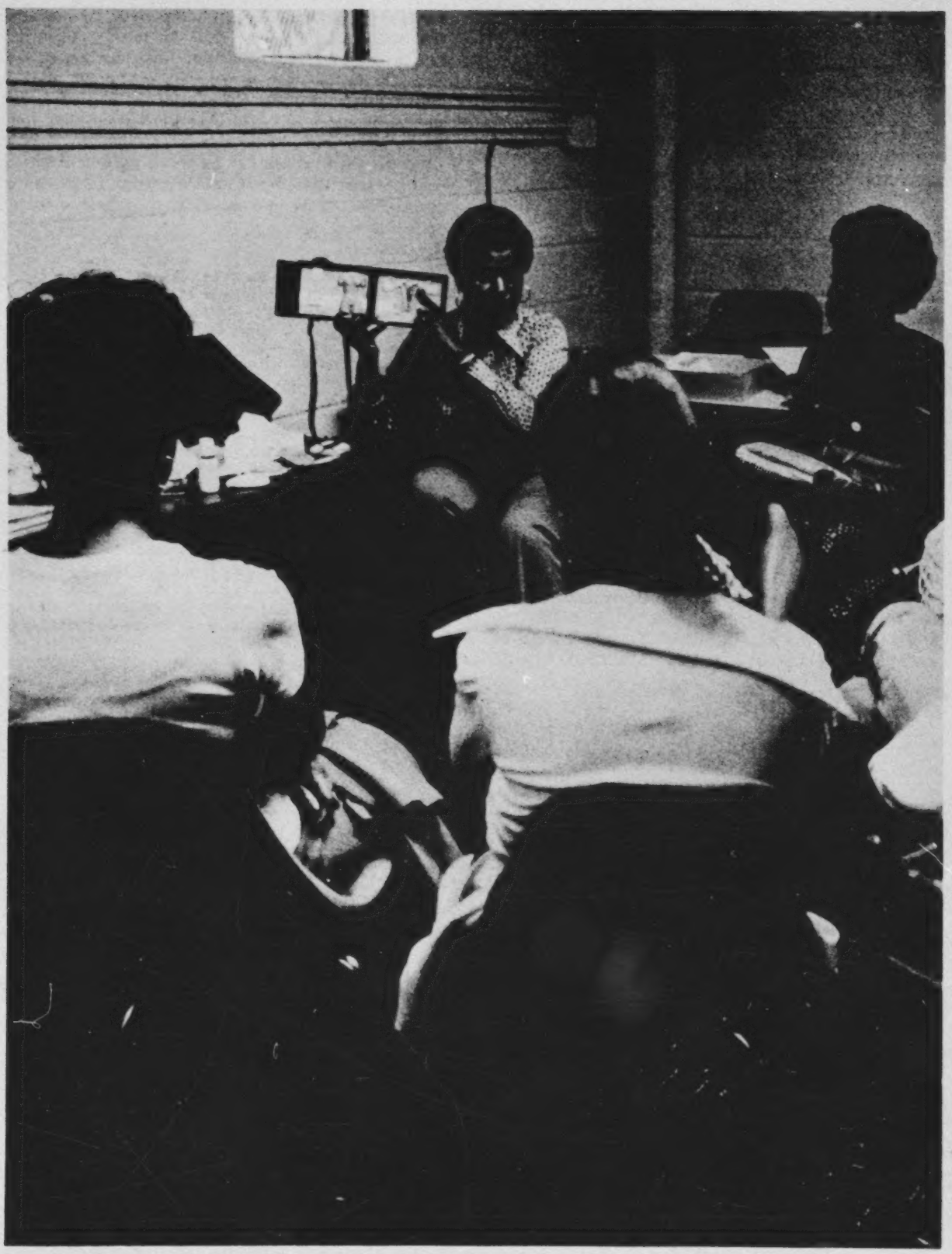

New Roles for Women in Health Care Delivery

A U.S. Response to the Cameroonian Experience

Jacquelyne Johnson Jackson, Ph.D.
Associate Professor
Division of Medical Sociology
Duke University Medical Center
Durham, North Carolina

(Read by Norma Jean Wilson)

As a discussant for Dr. Martin's presentation on "Utilization of Women in Health Care Delivery in Cameroon and Africa", I was asked to comment briefly upon that presentation and to make more extended remarks by discussing the topic from my own perspective, and, finally, to comment upon the applicability of the African Strategies she proposed to the United States' situation.

Comment upon Dr. Martin's presentation

With primary reference to the Cameroon, Dr. Martin has provided us with a general description of the major types of health problems confronting many underdeveloped countries. Inadequate resources, including those of monies, personnel, and training facilities, adversely affect the health status of their populations. For example, morbidity rates from preventable diseases could be reduced significantly if better preventative health measures were in effect. She also focused upon some problems not completely unknown within the United States. For example, more and more effective health education of their populations could aid immeasurably in preventing unnecessary diseases and illnesses, provided that individuals and families possessed sufficient or necessary resources, such as money, for practicing good health measures. In other words, she recognized clearly important linkages between good health care and societal supports. In addition, she noted such problems as maldistribution of existing health personnel, and, quite important, the crucial links between politics and health.

With specific respect to women, Dr. Martin described the generally extreme paucity of women in the top-level administrative and professional posts within the health care areas, discriminatory patterns and recent changes in those patterns which affected the likelihood of women holding such posts, and, at the same time, underscored the significant health roles exercised by women by noting "that the health of the family and nation is in the hands of women". She also underscored the opportunities for and necessity for women being effectively involved and coordinated in their health activities on the local level, a phenomenon which could be achieved more efficiently through greater flexibility of fund utilization on the local level.

My Own Perspective

Many of Dr. Martin's generalizations about utilizing women in health care delivery in Cameroon and Africa are apt when applied to utilizing black women in health care delivery within the United States.

First, as women, the vast majority have been and remain heavily involved in delivering home health care to their nuclear family members, other relatives, neighbors, and friends. But, unfortunately, the extent to which such factors as role segregation by sex occur within that health delivery is questionable, inasmuch as data are not available. However, I believe that patterns of role integration and segregation by sex among blacks in home health delivery are influenced significantly by such factors as socioeconomic status, health status and conditions of the relevant individuals, and differential employers' attitudes and policies about leave time for females and males with relatives or friends requiring care. In addition, and following Dr. Martin's admonitions about the important relationships between nutrition, sanitation, and similar phenomena and health care, roles played by both sexes should be examined by their provisions of both indirect and direct health care. When such is the case, then it is quite probable that both black females and males within the United States are responsible for and active participants in health care delivery.

Secondly, it is also quite true that substantial increases in competent health education could benefit many blacks presently without that education, in that better knowledge and understanding of health and related matters could conceivably lead to more effective preventive health measures, as well as greater conformity to sound health treatment procedures. The critical need to reduce substantially social conditions dysfunctional to good health, such as the absence of flush toilets within households, is still a major problem for significant proportions of our own black population. For example, according to the 1970 U. S. Census data, about 25 percent of all black women, 25 years of age and over in the South, lived in households

without flush toilets. But given sufficient health education and given sufficient monies or access to good health resources, what will then happen? While we do not know the answer to that, we must be ever cognizant of the fact that health attitudes and behaviors are also crucial variables in adequate or appropriate utilization of health care resources.

Thirdly, Dr. Martin's insight into the importance of political power and health care apply equally as well within the United States. For the most part, the lack of significant black political participation and power has adversely affected black health care. For example, the famous 1910 Flexner Report was influential in leading to the closing, I repeat, *closing* of at least six black medical colleges, with only what are now the Meharry Medical College and the Howard University College of
134 Medicine being able to "weather the storm". The grave problem was that governmental agencies were willing to (and did) enforce closure due to inability to meet the new rules and regulations, but those same agencies were unwilling to assist those black medical colleges in developing resources necessary for meeting those rules and regulations. Similar problems have arisen more recently with respect to many black proprietary nursing homes and the governmental Life Safety Codes. While such programs as Medicaid and Medicare have provided some greater access to health care, and while some limited enforcement of civil rights legislation has resulted in far fewer overt discriminatory acts, the problem of blacks receiving adequate health care, irrespective of their racial and socioeconomic status, has "gone underground". That is, more subtle forms of discrimination are occurring, as in the case of varying diagnoses, diagnostic tests, treatments prescribed, et cetera, being based far too often still on the basis of race and/or sex, a concern which leads me to the fourth, and perhaps the most important consideration of the utilization of black women in health care delivery.

Fourthly, Dr. Martin's generalizations about the use of women as formal health care agents are also appropriate for black women in the United States. That is, the vast majority of black women gainfully employed as health care agents have been employed within the "inferior" health care positions. For example, throughout this century, only about one of every ten black physicians has been female, due largely to educational discrimination practiced against black females by both black and white universities, as well as to normative traditions about "the proper female role." Unfortunately, too, far too many Americans, including blacks and whites, have been concerned about the dearth of black female physicians. Instead, far too many have been overly concerned about the proportion of black females within the black physician population as compared with the proportion of white females within the white population. As I have written elsewhere, such individuals have misled themselves:

> . . . not only by accepting uncritically the usual myths about educational and economic positions of black females compared with black males, but, most important, by juxtaposing black and white female comparisons in assessing black females and males. That is . . . [they were] overconcerned about showing that within their own racial groups, black females enjoyed higher statuses than white females. Even here, however . . . [they] failed to provide convincing data. For example . . . [Gerda Lerner's] comparative data about the proportion of females among blacks and the proportion of females among whites who were physicians and attorneys did not show the proportion holding medical or law degrees. They showed only the proportions within the labor force. Since black women with professional degrees are far more likely than comparable whites to be gainfully employed, such data are highly circumspect in showing what Lerner would have us believe (namely that "black women are somewhat better represented than white" . . .). The data would not be circumspect if appropriate controls for differential set ratios within the black and white adult populations, buttressed by extrapolations based upon equal proportions of black and white women with degrees in the labor market, had been established.[1]

And, as another example, one irony of the famous or infamous (take your choice) "War on Poverty" of the 1960's was the significant emphasis placed upon developing black females especially as paraprofessional health workers, such as nurses' aides, and the significant lack of emphasis placed upon their development as health professionals, such as physicians and dentists, and in crucially related academic and research areas, such as biomedical and behavioral scientists and in such related practical areas as health administrators and health insurance executives.

Thus, as I see them, and despite quite recent, albeit minimal changes, the crucial problems involving black women in the delivery of health care within the United States as health agents are those of racial and sexual discrimination. Every effort must be made to encourage and expand the number of black women within the health care professions, and, in addition, every effort must be made to have Congressional legislation enacted which will ensure sufficient training slots and stipends for them. Such black women must be encouraged to undertake training which will enable them to select carefully from a variety of career options, and a sufficient number of them should be encouraged to select crucial roles within the academic, research, service, and political arenas. My own judgment is that such black women should not be lulled falsely, as some black students were, into training programs producing primary care physicians so that they could better serve "the ghetto". What I am really saying is that black women can and must be utilized effectively throughout the wide spectrum of health care and related positions.

Applicability of the African Strategies

It has long been obvious that a specific grouping of strategies in a specific way may be highly effective within one sociocultural environment, and almost

worthless in another. Thus, while I cannot comment upon the probable effectiveness of the strategies proposed by Dr. Martin for increasing female utilization within the health care areas in Cameroon and Africa, in the main, I would reject those strategies for black women in the United States. That is, I would reject some of the specificities of those strategies, but I would accept the importance of (1) reducing health problems by improving social environments and socioeconomic status; (2) expanding competent health education; (3) increasing consumer involvement in health care organization; (4) increasing training and career options in the health care areas; and (5) increasing black female participation in top level decisionmaking posts. I would not urge black women to concentrate on health posts in areas of greatest manpower shortages, nor would I urge greater initial thrust on the local level (by now, we have had sufficient experiences with general revenue sharing to know that blacks, at least in the South, can put somewhat greater faith in Federal than in local revenue sharing, provided that the Federal Government implements and enforces its provisions), but on the Federal level, and I would begin urging that great thrust be made during 1976, inasmuch as it is obviously an election year.

And, in closing, I would also urge black women especially to consider carefully the proportion of their monies which are used to educate medical students within the United States, and to determine the extent to which they receive at least equal representation within that training group. Black women may also wish to consider the extent to which many hidden Federal subsidies to medical students might better be shifted to an overt loan status, since physicians are in a far better position to repay such loans from future earnings than are most other individuals educated partially at the "public trough". And I would urge black women to become more seriously concerned about the significant and increasing proportion of foreign medical graduates (FMG's) who are delivering secondhand services to far too many blacks, particularly within public hospitals and clinics. Here I reflect back upon an observation I made some four years ago when I discovered the significant proportion of foreign psychiatrists on staffs of State mental hospitals serving overwhelming numbers of black in-patients and out-patients, and, in one instance, my distinct chagrin when I discovered further that many of those particular foreign psychiatrists barely spoke English. I was consoled, although only briefly, however, when a friend who is a health care professional in Washington, D.C., informed me some time later that I should not have been surprised, since, within the District of Columbia, "niggers are only guests these days". That is, and he was quite correct, many of the occupational positions formerly filled by blacks within our various hotels, restaurants and other service positions are now filled not by native blacks (whose unemployment rate continues to rise), but by foreign blacks, foreign whites, and other foreign colors. So, unless black women want to continue only being largely patients these days, some critical action along the general lines Dr. Martin suggested should be helpful here, too, provided the proper coalitions are formed, and such coalitions should not involve cojoining only with the weak—female or male.

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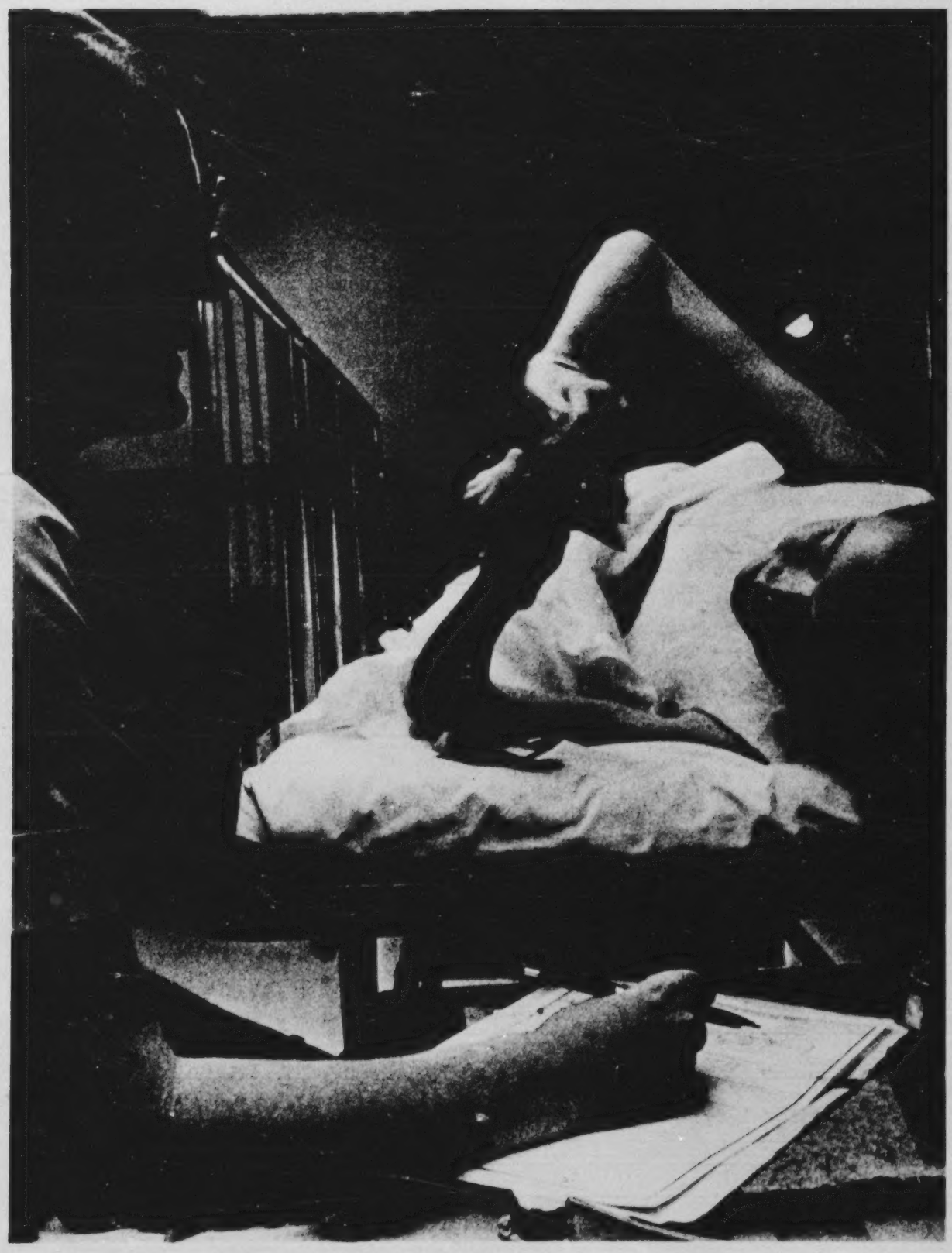


Analysis of the Role of Women In Health Care Decisionmaking

A Look at Poland

Magdalena Sokolowska, M.D., Ph.D., M.P.H.
Professor of Medical Sociology
Institute of Philosophy and Sociology
Polish Academy of Sciences
Warsaw, Poland

Introductory Remarks

This presentation is mainly based on the existing statistical data derived mostly from two Polish censuses, 1960 and 1970. Obviously, such materials are rather rough indicators of the social processes. However, they have a unique value: they present the changes and transformations of the society at large. The statistical indicators provide a factual, objective base for an analysis and control of the societal trends, in the social position of women, for instance.

It is well-known that such data cannot be easily compared cross-nationally and cross-culturally. It is hardly possible to venture comparisons without knowing characteristics of and differences between the structures and systems expressed by the statistical indicators. Often the same name or identical data have a completely different meaning in each of the compared countries. Besides it is hardly adequate to analyse exclusively data pertaining to health isolated from the broader societal context of which health is a part. Also processes of change of women's position are but one element of the general societal change.

Having this in mind I divided this paper into two parts: part one deals with the data aimed at presenting general trends of women's position in contemporary Poland; whereas part two deals with the same phenomena in the area of health. It is attempted to show a broad background and context of decisionmaking by women in health.

I. Some Determinants of Women's Present Position in the Polish Society

A. Education

Table 1 presents the process of a dramatic rise in the educational level of Polish women and men, in the country in which 30 percent of the population was illiterate prior to World War II. These data also reveal that differences in the educational level of men and women are being obliterated.

Table 2 shows the present situation in this area related to the age group 25 to 29 years: the educational structure is not identical for both sexes. For instance, the percentage of men with the basic vocational training is much higher than that of women, which partly explains the persisting higher wages of men as compared with women (jobs requiring a basic vocational training, mostly technical, are usually well paid).

Table 3 reveals the distribution rates of female students in the academic schools among various subject areas. Some words of explanation are needed: in Poland, as elsewhere, opinion divides occupations into "male" and "female" domains. The medical profession is universally regarded in Poland today as a female profession. There was a relatively large number of

Table 1: The Educational Level of Women and Men of Two Generations: Poland 1970

Education	18–24 years		50 years and over	
	Women	Men	Women	Men
	Percent			
All women and men	100.0	100.0	100.0	100.0
Higher including incompleted	6.8	4.5	1.5	4.8
Secondary including incompleted	53.7	55.5	9.1	15.3
Primary completed	36.4	35.8	36.4	35.0
Primary incompleted	1.9	3.2	36.3	37.2
Self-taught	—	—	6.3	3.8
Only able to read	—	—	2.5	0.5
Illiterate	0.2	0.2	6.4	3.3
No data	1.0	1.1	1.2	0.9

Source: Census 1970

Table 2: The Educational Level of Women and Men in the Age Group 25-29 Years, Poland 1970

Education	Women	Men
	Percent	
All women and men	100.0	100.0
Higher including incompleted	6.7	7.9
Semi-higher *	4.4	1.8
Secondary including incompleted	22.5	17.2
Basic vocational	10.1	22.9
Primary completed	51.1	45.5
Primary incompleted	4.6	3.8
No data	0.6	0.9

* schools of nursing, for instance
Source: Census 1970

women physicians already in the inter-war period (see table 9) and in the first post-war years the highest proportion of women in higher education was in medical schools. In the following years the proportons changed, which is probably attributable to the measures applied by the authorities to check the feminisation of studies in fields where it assumed great dimensions (table 3). Nevertheless, women constituted 50.2 percent of medical and 81.3 percent of dental graduates in 1973 (table 9). As table 3 shows, the proportion of women in the medical profession declined by half in 1951-1967, while their share in technical vocations doubled. This can be attributed to measures of another kind, namely, those aiming to stimulate a rise in the number of women students in fields where they are relatively few in proportion. As a result, there has been

a change in the structure of studies chosen by women which will most probably continue. The range of faculties chosen by women is expanding and is departing ever more and more from the so-called typical female preferences.

Nevertheless, there are visible differences in the occupational structure of women and men with academic education: While about 45 percent of women with academic training are concentrated in health and humanities almost the same proportion of men is involved in engineering. (Table 4).

B. Work

The proportion of women of the total employed outside agriculture was 39.3 percent in 1970. Diagram 1 presents participation rates of urban women in five age groups in the labor force in 1960 and 1970.

The rise of the proportion of working women in 1970 in each of the five age groups is observed; but interestingly enough, the increase was the sharpest in two age groups: 25-34 and 35-44 years, those periods in which domestic responsibilities are the greatest. Diagram 2 presents differences between Poland and USA in this respect.

Diagram 3 shows participation rates of urban female and male in the labor force by age.

Whereas in Table 5, general trends of the employment of married women are presented.

Differences between Poland and USA in this respect are shown in Diagram 4. At present as much as 75 percent of working women in Poland are married, and the majority of them are mothers. Neither the number of children nor their ages exert any great influence on women's vocational activity. Thus, 64 percent of mothers with children up to the age of three, 71 percent with the youngest children between four and seven and 74 percent with children of 14 to 18 years of age are working, as are 77 percent of mothers with one child and 63 percent with three children.[1]

After their maternity leaves, 70 percent of the mothers return to work. The influence of education and type of occupation on the decision in this respect is shown in Table 6.

Table 3: Distribution of Female Students in Academic Schools Among Various Subject Areas, Poland 1950-51 and 1966-67

Subject area	1950–51	1966–67
	Percent	
All students	100.0	100.0
Medicine, dentistry, pharmacy *	30.8	15.1
Humanities [1] **	20.8	22.6
Law and economics**	18.4	20.8
Mathematics, physics, ** chemistry, biology	13.9	15.6
Engineering *	6.4	14.8
Agriculture *	5.1	8.8
Fine arts *	4.6	2.3

[1] Including social sciences, psychology, education, Polish, foreign languages, journalism
* university
** Higher professional schools
Source: "The Woman in Poland", The Central Statistical Office, 1968

Table 4: Distribution Rates of Women and Men With Academic Education Among Various Subject Areas, Poland 1970

Subject area	Women	Men
	Percent	
All women and men	100.0	100.0
Medicine, dentistry, pharmacy	22.0	8.5
Humanities	23.2	11.7
Economics	13.4	11.9
Law and administration	5.7	8.3
Mathematics, physics, chemistry, biology	11.8	5.6
Engineering	11.5	41.5
Agriculture	6.8	8.6
Fine arts	4.0	2.3
Other	1.6	1.7

Source: Census 1970

Table 5: Participation Rates of Urban Married Women in the Labor Force in Four Age Groups, Poland 1960 and 1970

Age group	1960	1970	Difference
20–24 years*	51.3	65.5	+14.2
25–34	43.8	68.5	+24.7
35–44	39.2	66.0	+26.8
45–54	29.9	53.7	+23.8

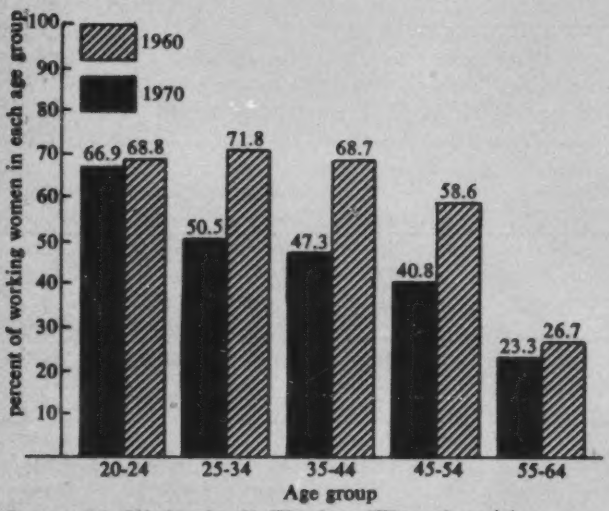
* For 1960 age groups 18–24 years
Source: Censuses 1960 and 1970

Table 6: Married Women at Work Six Months Following Maternity Leave, by Occupation, Poland 1963

Occupation	Percentage at work
—Teachers	94.7
—Doctors and pharmacists	94.2
—Nursery school staff	84.9
—Engineers and technicians	84.2
—Production workers in industry and construction	
skilled	70.0
unskilled	49.9
—Charwomen	48.0

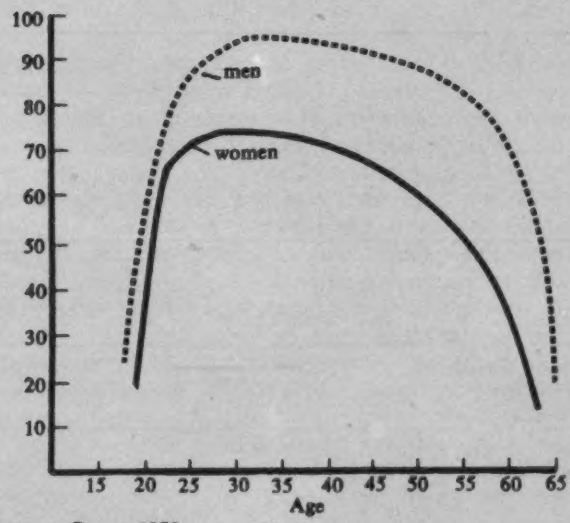
Source: A. Kurzynowski, *The Continuity of Work and Maternity*, Warsaw 1967.

Diagram 1: Participation rates of urban women in five age groups in the labor force, Poland 1960 and 1970



Source: M. Sokolowska, K. Wrochno; "Women's social position in the light of Statistics," *Studia Sociologiczole*, 1965, 1 and Census 1970.

Diagram 3: Participation roles of urban females and males in the labor force by age, Poland 1920



Source: Census 1970

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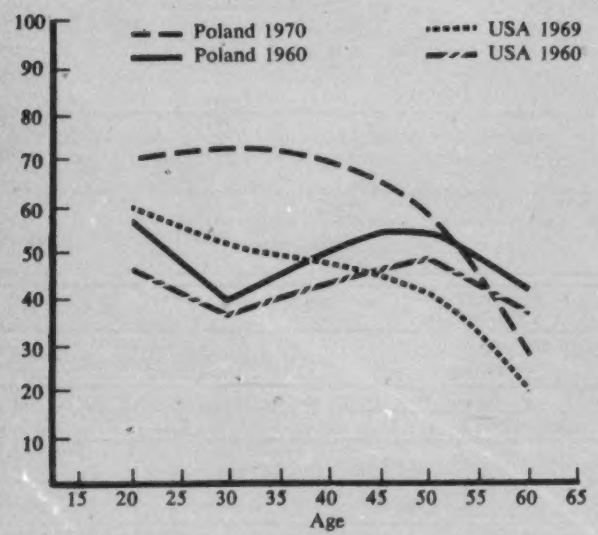
C. Participation in the Social and Political Life. Managerial posts—"Decisionmaking"

For most working women in Poland "top" positions are unattainable simply because there is no equality in family duties. Everyday observation proves that a regular job, even in an academic profession, can be sometimes "fitted" into the pattern of life, and that job and family duties can be reconciled without turning all the aspects of life upside down. However, managerial positions cannot be held by women without radical changes in the occupational structures which now are better fitted to the needs of men than women. Managerial positions mean irregular job hours, concentration on work and subordination of the other aspects of life to it.

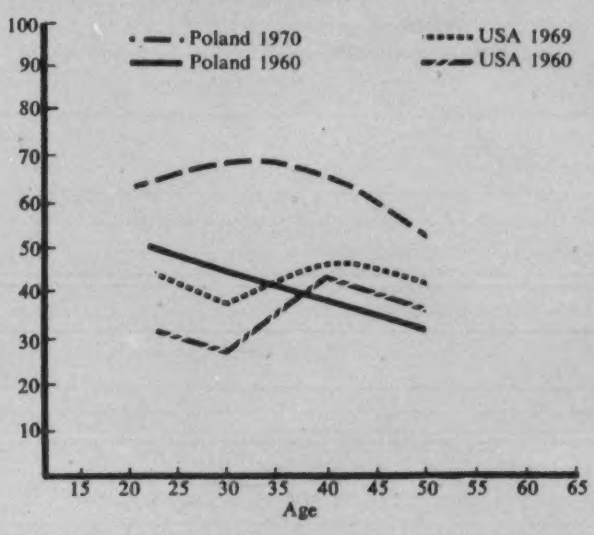
There is a striking disproportion between the enormous changes in the roles of men and women outside of their homes and in their family and household roles. The revolution has transformed the relationship be-

Diagram 2: Participation roles of women in the labor force, Poland (urban women, 1960 and 1970) and USA (1960 and 1969) by age



Source: Censuses 1960 and 1970—and A. L. Ferris: *Indicators of trends in the Status of American Women*, New York, 1971.

Diagram 4: Participation rates of married women in the labor force, Poland (Urban women, 1960 and 1970) and USA (1960 and 1969) by age



Source: Censuses 1960 and 1970—and A. L. Ferris: *Indicators of trends in the Status of American Women*, New York, 1971.

tween social classes, but it has by no means automatically changed the relations between family members. The patterns of family life change at a much slower pace. Many husbands, and wives too, still stick to the traditional image of relationship between the spouses and between children and parents, as well as to the patriarchal model of power in the family and the ensuing division of responsibilities and duties. Let us not forget that almost half of the Polish population lives in villages and that the Catholic Church still exerts its powerful influence. But the social and economic background, once sufficiently justifying the traditional images and models, has changed radically. In the new situation of a family in which a woman earns her income, the strategic problem is that of a redefinition of the roles of the husband-and-father and of the
140 wife-and-mother.

The fact of employment of a wife-and-mother has not influenced very much the distribution of domestic chores. Though in the families of working women the contribution of the husband and of the other household members is twice as high as in the other ones, still it remains rather meagre.[2] A relatively small proportion of women benefit from communal services such as: canteens, laundries, etc. The bulk of household work continues to be done at home and belongs to the sphere of activity also of the working woman.[3]

Seventeen percent of urban working women use the day-care center for their children under three years of age. Forty-eight percent use the kindergarden. Fifteen percent of the urban families with women aged 21-47 years live with their parents. Families with women aged 21-34 years live with parents almost five times more frequently than families with women aged 35-47 years. About 30 percent of children of the young couples are reared by grandparents.[4] Nevertheless, care and rearing of children is mainly the mother's task (Table 7).

Table 7: Percentage Division of Child-Care Responsibilities Between Mothers and Fathers, Poland 1967*

Mother's occupational	Children aged 0-7 years		Children aged 8-18 years	
	Mother	Father	Mother	Father
	Percent			
Working	81	19	78	22
Non-working	93	7	88	12

* Nationwide representative urban sample of 1,677 married women aged 21-48 years and 500 husbands (all child-care functions=100)

Source: J. Piotrowski; "Family needs resulting from an increased employment of married women," 1969.

However, there are already examples showing changing attitudes and behaviour also in this area. Pioneers of the new pattern of family relationships are young married couples of professionals living in cities, "dual career" families. A study of a group of couples in which both husbands and wives are engineers, living and working in Warsaw revealed that there is an actual partnership there.[6] It is expressed in more equal division of the domestic duties, in common child-care, common holidays and pastimes. An important place in the marriages of young engineers is occupied by professional discussions and by mutual help in those matters that concern them as a couple. None of the women engineers seriously considers the possibility of quitting her work for good, since they see their professional activity as an indispensable element in a woman's life, like having a family. The couples of young medical doctors were never studied in this way but I suspect that the results would be similar.

New patterns of life have been traditionally modeled by the educated class in Poland. The way of life and the cultural patterns of the "enlightened" have for centuries provided progressive models of the systems of values. Thus, it may be expected that the new patterns of family relationships, being now shaped by the educated and professionally active, will be accepted and adopted by the society at large. These patterns arise as a result of rationalization and individualization of social behaviour of individual people and families. Underlying them are far-reaching changes in the systems of values cherished by men as husbands and fathers and by women as wives and mothers.

Polish data also reflect the universal phenomenon of the decreasing share of women as we move up the hierarchy, even in the most feminine occupations. The percentage of women in top positions, as in other countries, does not correspond to the percentages of educated women in general and to the proportion of men in those positions (Table 8).

The proportion of women among full professors is 5.2; among associate professors, 11.5; among dotsents (A) 15.5; among doctors, 28.0.[5] The proportion of women among deputies to the one-chambered Parliament (Sejm) was as follows:

1952-56	17.4
1957-61	14.4
1961-65	4.1
1965-69	12.4
1969-72	13.5
1972-	15.9

In government administration there are almost no women:

Council of State (B)	1
Council of Ministers (C)	–
Ministers (Secretaries of State)	–
Vice-Ministers	2
Foreign Service: Ambassadors	–

The Editorial Boards of three leading Warsaw weeklys; "Polityka", "Kultura" and "Literatura" include 75 members; there are four women among them.

(A) The degree of dotsent (venia legendi) roughly corresponds with the title of associate professor in USA

(B) Composed of president, four vice-presidents, secretary and 11 members

(C) Composed of president (prime minister), six vice-presidents and 22 ministers (the number of vice-presidents and ministers is a subject of change).

Table 8: Percentage of Women in Higher Work Position of Polish Industry, 1964 and 1968

Position	1964	1968
	Women as percent of total workers in position	
Director	1.9	1.5
Chief engineer, vice-director for technical affairs	2.2	2.3
Vice-director for management	3.6	4.6
Chief mechanic, chief power engineer, chief technician	2.7	4.2
Head of production section	8.2	7.1
Section mechanic, power engineer, technician	9.7	13.9
Senior foreperson	1.7	4.0
Foreperson	3.9	5.0
Chief bookkeeper	38.2	30.6
Director of finance section	17.5	23.6
Senior financial consultant	37.6	58.2
Financial consultant	50.8	76.9

Source: Statistical Yearbook of Work 1945-1968, Quoted by K. Wrochno, *Problems of Women's Work*, Tradeunion Publishers, Warszawa 1971.

II. Women in Decisionmaking in Health

Health was never studied in Poland in a way relevant to the present paper (A) and the only existing data I was able to use in this paper consist of the routine statistics. However, it seems to me that these data, together with the first part of this paper, are sufficient to give a notion and general idea about the problem.

Under "women" three groups of professionals are understood: physicians, dentists and pharmacists. They are the only academically trained professionals "specific" to health.(B)

No attempt will be made to define precisely the complicated and somewhat vague term "decisionmaking". There are several levels of decisionmaking in health and at least two main forms: professional and general managerial. The first involves definite qualifications and skills of a physician, closely connected with his or her professional role. The second form relates to the area where there is no clear test of performance and demonstrated experience does not guarantee competence in a current task.

Speaking about the first: professional form of decisionmaking in health, I have in mind a doctor who is a healer of the sick individual.[7] A healer operates at a direct, most dramatic level of decision involving questions of life and death of a given person. Obviously, it is a highly specific area of choices and decisions and it seems that just because of it the doctor enjoys such a high prestige in modern society. The high proportion of women physicians in the socialist countries—a proportion unequated anywhere else in the world—may be interpreted as a tremendous gain by women of a unique power and rights granted by society to its scientific healers.

No research was carried out in this field but it seems that the variable feminine sex does not influence the authority of a doctor. In spite of "feminisation" of medicine he or she enjoys a very high social prestige. In Poland, the variable feminine sex is probably less important than the highly specialized professional role. Perhaps it is due to the fact that the population became used to the image of a woman doctor who in Poland has a long tradition in medicine.

Table 9 shows the number of physicians, dentists and pharmacists of both sexes in the years 1921-1973 and the increasing percentage of women in these professions.

Table 9: Number and Percentage of Female Physicians, Dentists, and Pharmacists, Poland: Selected Years, 1921, 1960-1973

Year	Physicians	Dentists	Pharmacists
	Number of Women		
1921	656	1,296	569
1960	11,024	7,285	5,856
1970	23,459	11,066	9,924
1973	27,575	12,269	11,505
	Percent		
1921	12.0*	51.1	16.0
1960	38.4	78.2	73.9
1970	47.6	81.3	80.7
1973	50.2	81.3	83.1

* 20 percent of doctors in 1931 were women
Source: Statistical yearbooks.

Already in 1921, the first census in Poland revealed a relatively high percentage of women physicians and dentists practicing medicine (table 10).

Table 10: Percentage of Women Physicians and Dentists in Solo Practice and Employment, Poland 1921

Type of work	1921 women	
	Physicians	Dentists
	Women as percent of total in type of work	
Independent-solo practice	16.1*	50.2
Employee	14.2	49.7

* 28.2 per cent in 1931
Source: Censuses of 1921 and 1931.

Table 11 shows the distribution and proportion of women with doctoral and dotsent dissertations in selected specialties of medical sciences: these where women predominate (pediatrics, ophtamology, micro-

(A) For instance I have in mind such studies as "Women in Medicine" by M. Jefferys, "The Female Physician in Public Health" by J. Kosa and R. E. Coker or the already quoted Polish study of the married couples of engineers by B. Lobodzinska, which could be carried out in a similar way on a group of married couple of physicians.

(B) Medical schools in Poland do not belong to universities. They are supervised by Ministry of Health and Social Welfare and they are composed of three faculties: of medicine, of dentistry ("Stomatologia") and of pharmacists. There is a newly established faculty of nursing in one of the medical schools but there are no data yet indicating the role played by its first graduates in the health system.

biology), where they constitute almost a half (biochemistry and biophysics, medicine), and where the proportion of them is the smallest (obstetrics and gynecology, surgery). These data point out the wide range of specialties chosen by women doctors and dotsents for their careers in the higher academic or professional ranks. Even in surgery, the most traditional masculine area of medicine, the proportion of women is quite impressive (16 percent).

Table 11: The Total Number of Dissertations for Doctor and Dotsent Degree in Medical Sciences and Percentage of Women by Selected Specialists, Poland 1960-1969

Specialty	Doctoral dissertations		Dotsent dissertations	
	Total Number	Percent of Women	Total Number	Percent of Women
Pediatrics	293	74.1	39	74.3
Ophthalmology	93	66.6	27	51.8
Microbiology	129	62.7	33	39.3
Biochemistry, biophysics	139	46.7	41	17.0
Medicine	723	38.8	135	22.2
Obstetrics and gynecology	276	20.2	48	12.5
Surgery	666	16.6	129	6.2

Source: Statistical Yearbook of Science, 1971.

The percentage of women physicians holding the degree of doctor and dotsent increased markedly between 1968-1973 (Table 12) and it is much higher than the proportion of women in all disciplines holding doctoral and dotsent degrees.

Table 12: Percentage of Women Physicians Holding Doctoral and Dotsent Degree and Nominated to Professors, Poland 1968 and 1973

	Professors	Dotsents	Doctors
	Percentage of women		
1968	13.8	20.8	32.7
1973	12.0	25.7	36.9

Source: Census of Personnel, 1968 and 1973.

In fact both the percentage of women among persons holding the highest academic degree of dotsent (25 percent) as well as the degree of doctor (37 percent) are rather impressive, as compared with many other countries. Undoubtedly, the decisive factor is a large number of women physicians—the existing "supply". Their pressure upwards results in breaking the consequent barriers and permeating the occupational structures at the consequent levels with women.*

On the contrary, it seems that there is no similar ladder from the occupational to the general managerial structures. Although for managerial positions in medicine in Poland medical qualifications are required, it is not sufficient proof of competence in areas of general management. As the British authors state:

> "Women have been able to win acceptance in senior posts most easily when these posts require a definite qualification which a woman can show that she has, as with a doctor or research scientist. . . . But today management too is coming to include an increasing element of definable and respectable skill. The route to the top in management leads more often, and over a greater proportion of a career, through specialized fields where a demonstrable skill or qualification is required. . . . It is at least a possibility that as these trends develop, the opposition to women in management will crumble as that to women as individual performers at senior levels has already done".[8]

It is the area of general management that masculine prejudice operates most strongly and men's judgement of what women can be expected to achieve is furthest from reality.

> "Here are the major power centres and the area where threats of competition are likely to be most strongly felt. Here is also where the optical illusion of family is likely to have most effect. The mother of the family may well have a special skill in this or that domestic or other art as well as high skill in informal relationships. Men who are used to seeing a wife exercise these skills at home will not be greatly surprised to see her or another woman exercising skill of the same type in a work situation. But the style of overall management in a home is likely to be different from what is appropriate to the control of large formal organisations . . . It is again of course in management that, because too few women have yet the chance to reach management positions, the self-fulfilling prophecy operates most strongly: the tendency to force low levels of aspiration of women and for women themselves to live down to them." [9]

Table 13 mirrors this situation to a certain degree.

Table 13: Percentage of Women Administrators, Selected Managerial Posts in Health, Poland 1973

Ministry of Health and Social Welfare	
Secretary of state	—
Deputy secretaries of state	—
Directors of divisions	—
Heads of departments of health, voivodship level	—
Directors of community health centres	6.5
Deputy directors of community health centres	15.4
Directors of hospitals and out-patient clinics	38.6
Deputy directors of hospitals and out-patient clinics	25.7
Chief physicians in hospitals and deputy chiefs	36.9

Source: Census of Personnel, 1973.

It is an unexpectedly high percentage of women among directors of hospitals and out-patients clinics (38.6) that seems to be a new development. The post of the director of a hospital can be located "in-between", between the professional structure and the managerial one. A high proportion of women occupying this post represents an interesting trend which should be carefully observed.

Another interesting phenomenon is revealed by Table 14: women administrators are younger than men at the corresponding posts.

* The lack of increase and even the slightly decreased proportion of women among persons given the title of professor may be explanied by the fact that the main wave has not yet reached the level of professorship. Professors are usually older or much older than dotsents.

Table 14: Age of Men and Women Physicians in Health Management, Selected Posts, Poland 1973

Post	Total	Age Groups					
		Under 29	30-39	40-49	50-59	60-64	65 & over
Directors of community health centers:							
Men	100.0	0.2	26.8	60.6	11.0	1.1	—
Women	100.0	8.1	18.9	56.7	13.5	2.7	—
Directors of hospitals and out-patient clinics:							
Men	100.0	1.4	20.5	46.6	18.5	6.7	5.6
Women	100.0	3.6	37.2	43.3	13.0	1.2	1.5
Chief physicians in hospitals & deputy chiefs:							
Men	100.0	0.2	16.6	50.8	20.7	7.7	3.7
Women	100.0	0.4	29.1	49.6	17.4	2.5	0.7
Heads of rural health centers:							
Men	100.0	14.6	46.8	31.1	4.8	1.4	1.0
Women	100.0	28.8	48.3	17.3	4.5	0.3	0.5
Heads of other health establishments:							
Men	100.0	6.3	27.8	28.3	19.1	10.1	8.0
Women	100.0	11.3	35.4	30.1	17.1	4.3	1.5

Source: Census Personnel, 1973.

The preoccupation with the general management area should not leave other phenomena out of the attention of the students of decisionmaking in health. Table 13 shows that 37.0 percent of chief physicians in the Polish hospitals are women. It means that in our country the professional decision in health at a high level of competence and responsibility comes almost equally from men and women.

Conclusions

Materials presented above reflect both the universal and the local socialist—Polish traits of the present phase of the process of change in the position of women in society. A few words about the universal side of this process: it was only a few decades ago that the first women ever stepped into the colleges and universities. Time has passed rapidly indeed; we must concede this, if we think about the enormous scope of change that has occurred: from the struggle for admission to universities, to about one-sixth of women among college professors in Poland; from only a few women physicians at the beginning of the century to almost a half of the profession now; from researches on "the delicate feminine organism" to prove that academic studies are noxious for women, to space exploration tasks in which women participate.

As far as the local socialist-Polish side of the story is concerned: The data presented show a somehow slow but steady increase in the percentage of women as active participants of the social and political life. The coming years will bring further changes. In socialist countries there are favorable conditions for such changes. This is evidenced by at least three facts: 1) A great majority of working women continue to be employed during their whole lifetime, similar to men. This is a basic precondition of avoiding playing a marginal role at the place of work and to becoming a necessary member of the staff, with opportunities for advancement. 2) There are high percentages of women in the professions. Professional work, e.g., of a physician, is a responsible one at any level. Still, women professionals are by no means exceptional: a woman as a physician, dentist, lawyer or even engineer can be met everyday in Poland. 3) The barriers to winning scientific degrees by women still exist, but at higher degree levels, principally.

The socialist countries have shown to what extent the position of women can be changed by changing the macro-structure of society. This was achieved by the appropriate systems of law, education and employment. Further changes depend on transformations in social micro-structures: in human and family relationships and in the traditional feminine and masculine role images. Human consciousness in this field, as much as in others, changes less rapidly than the economic or political institutions.

The health area in Poland is an exciting laboratory for studies on these processes of change.

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Analysis of the Role of Women in Health Care Decisionmaking

A U.S. Response to a Look at Poland

Nina B. Woodside, M.D., M.P.H.
Director, Center for Women in Medicine
The Medical College of Pennsylvania
Philadelphia, Pennsylvania

It is a privilege for me to discuss Dr. Sokolowska's excellent paper on the vital subject of the role of women in health care decisionmaking.

I will begin by giving my specific reactions to a number of the points made by Dr. Sokolowska. Then I will attempt to relate her presentation to factors influencing the status of women in health care decisionmaking in the United States and to suggest some strategies for improving their status.

Dr. Sokolowska made a very good point about decisionmaking being of two types in the health field—professional and managerial. I strongly agree and the distinction between the two should not be overlooked.

Dr. Sokolowska also mentioned several factors which in Poland may be keeping women out of management: the lack of any training or educational program in management; male fear of competition from women; and the so-called optical illusion of family responsibilities as an impediment. She also pointed out that in Poland there are no clear career ladders for progression from professional practice to managerial level of decisionmaking. She implies that, as in England perhaps, as specific training and definitive credentials for a field of management are developed, women will go after the training and credentials and move ahead into management. Now, however, she feels managerial positions are not feasible for women in Poland because of irregular job hours, and the need to concentrate on work and subordinate other aspects of life to it. Is this true here? Perhaps I am too optimistic for the U.S. but this conclusion is hard for me to accept. In this country, there are several educational routes for training both physicians and nonphysicians in administration or management: public health administration programs in schools of public health, health care administration programs at graduate and undergraduate levels in schools of government and business administration or other schools in universities, and medical care administration programs in a variety of schools and universities.

Dr. Sokolowska also noted that in Poland an increasingly higher percentage of directors of hospitals and out-patient clinics are now women and that female administrators are younger than the male ones, a recent phenomenon. Also 40 percent of their decisionmakers at this level are women. Such is not the case in the U.S.

I don't believe I agree with Dr. Sokolowska's comment that home management skills which women have are not applicable to the management of larger organizations. I would like to see some research on this subject.

I was somewhat surprised to learn that family relationships have not changed much in Poland in spite of the major socioeconomic changes. Again, I wonder if I am too optimistic for the U.S. Polish women still have the advantages of the extended family to a greater degree than I think we have here. Their new life styles in dual career families, however, seem very similar to ours.

It is disappointing that in Poland as in the U.S., top positions in the health field are not accessible to women. What does this portend for us here? Unless we apply some preventive strategies now we may continue in this same fix! All physicians are very good at professional decisionmaking, regarding the individual patient, because that is how they are trained and the sex of the physician makes no difference. Not all physicians are good at general managerial decisionmaking or even like it or desire it. Most physicians enter medicine in the first place to do the professional decisionmaking. However, why should the managers be mostly male? How do the males get to be the managers? Should women be managers, too? And if so, how? That is what we are discussing in this session.

Maximum changes have been made in Poland in the macrostructure of society—that is, in laws, education, jobs, and so forth. We are only beginning to work on some of these here. In the U.S. we have been putting our efforts, through the feminist movement, for example, on changes in the microstructures of society—that is, changes in human and family relationships and in traditional male and female role images. How do we combine the best of both kinds of approach and speed them up in order to improve the status of women in health?

Factors Influencing Status of Women In Health Care Decisionmaking

It is my observation that women's problems in achieving status as decisionmakers in health care are primarily due to factors in professional life on the one hand and personal life on the other. Secondarily, they face problems as a result of the influences of these two factors.

The primary professional factors are well known. Among these is the reluctance to lose opportunities for patient contact or contact with clinicians by going into administrative activities. This is aggravated by the psychological and sociological barriers that women face because they do not have access to the informal channels of communication among their male peers, by the real hardships of being the token or solo woman in a decisionmaking body, by the relative lack of credentialing by medical specialty board certification compared to men, and others.

Other professional factors hampering women's achievement of decisionmaking status are periodic unprofessional statements by detractors in both public and professional media to the effect that women are unfit to hold high office because their decisionmaking process is influenced by their menstrual cycle and destructive statements by observers of group functioning or team functioning who feel that women have a subculture of their own which causes them to be dependent, flirtatious and politely competitive, which in turn causes considerable delay and difficulty in decisionmaking in teams consisting largely of or led by women.

And, not least of all, women are adversely affected by the simple lack of awareness among men in the medical establishment, voluntary agencies and policymaking boards and committees about the role of women in decisionmaking and how to improve it.

Primary factors in the personal life of women which can be problems in achieving status in decisionmaking include confused self-identity and fear of success. Women function within and without the health care fields as patients, providers, and procurers of health services for their family. They must meet the demands both of the professional role and the personal role as homemaker. The expectancy that success in achievement related situations will be followed by negative consequences arouses fear of success in otherwise achievement motivated women which then inhibits their performance and levels of aspiration.

These professional and personal life factors and others create many problems for women. They contribute to the systematic exclusion of women from decisionmaking positions and their resultant powerlessness in the health sector.

Women physicians often co-opted by the male medical establishment consciously and unconsciously have adopted the exclusionary attitudes of their male colleagues and frequently are accused of becoming "one of the boys". They may unwittingly neglect to use the power that their prestige would give them to increase the options for all women in health care. Also, the highly skillful and successful kind of woman now reaching decisionmaking level is often held up as a standard which other aspiring women must meet—as superwomen—in order to acquire decisionmaking status.

Where women are subjected to curricula and textbooks geared to "traditional" male and female roles, they are crippled in their creativity and stifled in their intellectual development but more importantly they are at risk of falling into the trap of elitism whereby physicians are not at ease relating to women at lower ranks in the health field.

Another result of all of these factors is the downgrading effect which may be produced by rapidly increasing the number of women in a particular field. A current example in the United States is the field of comprehensive health planning which is seen by some educators and practitioners as a "good" field for women as opposed to the field of health administration. My observation is that salaries and rank will be lower, if they are not already, in the planning field than in administration.

Some Strategies to Improve the Status of Women in Health Care Decisionmaking

In light of what we know about these and other problematical factors, what strategies can be identified to improve the status of women in health care decisionmaking positions? I have identified some ten strategies: extra market role evaluation; political and public involvement; career options and career advancement; acquisition of management skills; assertiveness training; career path reassessment and lifelong learning; new career patterns and institutional changes; networks for various purposes; affirmative action and legal routes; realignment of responsibilities in the home. I will discuss most of these briefly; some are self-explanatory.

Extra Market Role Evaluation

Women as health advocates for their family have great experiences in utilizing the health care system. Also women are active in uncompensated work in voluntary health agencies, in the provision of child care in their home as well as care for aged dependents or sick family members, and are also responsible for the feeding and nutrition of their family. These services are related to but are outside of the health system, the so-called extra market services. Thus women, because of their currently unique role, serve as the interface between these nonpaid but health related responsibilities and the health system. These contributions to society by women today need economic analysis. Certainly women (and men) should recognize the value of these experiences as planning, coordinating, and decisionmaking activities.

Political and Public Involvement

Women need greater involvement in the political process and public life, as you have seen and heard throughout this conference. The proportion of women

holding policymaking positions in the legislative, judicial, or executive branch of government is growing but remains pitifully small in most nations including the United States. Moreover, where women have government posts they often are entrusted primarily with responsibility for women's kinds of programs, such as maternal and child health activities. Women health workers including physicians must be involved in public and political processes enabling them to speak for matters related to their profession, such as better services and research regarding the health of women, social services for the aged, improved services for prisoners, research in male and female contraception, the mental health of women and others. It is an unfortunate and even offensive oversight that not a single woman is included on a recently appointed committee in the executive branch of Government for the purpose of advising the President on expenditure of scarce funds for biomedical research.

Career Options and Career Advancement

At the 1974 Action Planning Workshop sponsored by the Center for Women in Medicine, participated in by many of the men and women here today, a series of recommendations for research and for program development were made regarding increasing career options and promoting career advancement to acquire power for women. Research was recommended to determine who controls professional groups (for example, surgery compared with pediatrics), to determine the representation of women on decisionmaking committes and in professional organizations, to identify officers in various professional organizations, to identify how panels and programs for professional meetings are organized, to identify who hires, and to evaluate affirmative action plans for each medical school. Once these and other data are available presumably appropriate action can be taken to increase career options and advancement.

Acquiring Management Skills

Women physicians still are less apt than men to enter entrepreneurial activity such as private solo practice. Therefore, they need management and decisionmaking skills in order to take leadership roles wherever they find themselves practicing—whether they are in medical teaching, group practices or organized centers, or are salaried in government, hospitals or other institutions or community agencies, or are doing research. It should not matter whether they are working full-time or less than full-time or in some flexibly scheduled arrangement. The 1974 workshop, referred to earlier, recommended the establishment of effectiveness workshops to train women physicians and other health workers in management skills covering topics such as how to be invited to join professional meetings and decisionmaking committees, how to influence behavior at professional meetings, how to become a leader and influence behavior in group setting, how to influence policymaking committees, and what are the rules and routes to obtaining funding. This effectiveness or "how to" training can be carried out on the job through relationships between educational institutions and operating agencies or organizations. Certainly universities can be encouraged to respond actively to these imperatives for training for social change. Such training programs in self-development for women in management might include discussions about developing self-awareness as women, improving interaction with others in organizations, developing managerial skills, integrating professional and home life, and translating awareness into action.

Assertiveness Training

When women have acquired these management skills they must then put them to use. Women, including highly educated professional women, benefit from assertiveness training. Women themselves and the men who are sensitive to their problems must assertively pressure for the inclusion of women in policymaking on voluntary and professional boards, committees, and task forces, on panels in the Department of Health, Education, and Welfare, on health planning bodies, and on governing boards of health care institutions. They must pressure for employment of women in policy and decisionmaking positions at all levels. Collectively women and men in all health occupations must achieve power over their own conditions of work and practice, the content of their discipline's knowledge base and credentialing in their field.

As women move into these decisionmaking positions we must be assured that there is always more than one woman so placed. If a solo woman is involved she is subjected to becoming a deviant member of the group, isolated, or low in status. If one finds oneself the solo woman in a decisionmaking group there are strategies for increasing effectiveness and avoiding depression. Such a woman must become independent, assertive, and competent in group functioning. Group leaders, of course, also need some training in allowing for and maximizing the effectiveness of women in the group. Men have more opportunity to learn how to function in a group early in life. One way to give such opportunities to women is to begin to include them as students on decisionmaking committees.

Career Path Reassessment and Lifelong Learning

Other strategies which are becoming important in improving the status of women in decisionmaking positions are periodic career path reassessment on the part of women and new institutional arrangements on the part of the health care system. Less than full-time activity or even discontinuity will continue to be a fact of life for women in the health field. For both men and women who are working full-time and continuously, as well as for those working less than full-time, continuing education, re-education, and periodic opportunities to learn new material in their field is essential. Early in their professional life women especially should become familiar with what these opportunities will mean to

them and such opportunities should be closely coordinated with their periodic career self-assessment. Retraining and re-entry opportunities as well are mandatory for women (and men) who have been inactive or who have worked in highly specialized areas of research or teaching and wish to return to clinical activity. In order to maintain their career commitment women need both the same opportunities as men and also special opportunities to keep up with the explosion of knowledge and to fulfill their life in these times of increasing longevity. Because of the trend toward more complex educational and occupational patterns for both men and women, the innovative programs developed to meet women's needs are being sought by men as well. Without such programs women cannot be or feel maximally competent to function in decisionmaking
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New Career Patterns and Institutional Changes

New career patterns and institutional rearrangements are by no means limited to women but will offer women an advantage in improving their status in decisionmaking in the health field. Such things as reduced schedule graduate training, flexible schedule or shared-time jobs, commuting life style, partnership or peer working arrangements with spouse, group practices, and team teaching or team service provisions, will all help women overcome the barriers to full involvement in the mainstream of health care including decisionmaking and prevent their being only on the fringes. Also in this regard, many of us here are calling for the introduction of institutional democracy in the health sector as a political strategy for change, with control of the institutions by those who work in them (the majority of whom are women) and those who are served by them; that is, more equitable socioeconomic class representation in the health sector as well as the representation of women and other disadvantaged groups.

Networks for Various Purposes

Women must learn to support one another and encourage one another to take leadership roles. There is a need for a systematic national communication network for women in health care. Research is needed to identify women health workers who are available to communicate about women in health care. Through such tools as a newsletter and a speaker's bureau, a network of concerned women in leadership positions could be responsible for a women's focus at each national conference of a health or professional association and for periodic meetings of persons with particular interests in women in health careers, health care delivery, and health care decisionmaking.

Likewise there needs to be developed extensive national networking through talent banks, job banks and placement services to identify and match up qualified and willing women with opportunities for service in decisionmaking groups and positions. To help in the attainment of an adequate self-image for women in health fields, there is a need for supportive groups and individual relationships to provide role models and to share, compare, and examine feelings, experiences, and behavior. Women in the health professions should share in the expression and solution of problems common to all. Women need continuity of peers among other women, for once they get through their professional education they frequently lose touch with women colleagues they had in high school or college and find themselves relatively alone on the fringes of a man's world. We need to develop a "biddy" system in contradistinction to the buddy system that men traditionally use to recruit and place their peers.

Such networks can serve a variety of other purposes such as mental support for coping with problems, career counseling, as a consortium approach to continuing education and training in management skills, for increasing awareness of sex roles in health occupations and the relation to socioeconomic status, for raising awareness with regard to health needs specific to women, and for identifying and placing women in decisionmaking capacities. These networks of women do not necessarily need to exclude men at all times and further they should be representative of students, faculty, and staff, at all ranks of work in the health care system.

Affirmative Action and Legal Routes

Another strategy to improve the status of women in decisionmaking positions utilizes affirmative action and other legal routes, with which you are all familiar and don't need to hear about any further from me.

Realignment of Responsibilities in the Home

And finally the most important strategy of all must take into consideration the conditions for women in the home place as well as in the work place. This means changes in the microstructure of society. In the long run changes in the socialization and life of women and men at home will be the ultimate and permanent solution to the question of the status of women in decisionmaking positions. Programs to improve home conditions must include day care centers, school systems and other institutions to care for and educate their children, plus the development of a variety of services which make it easier to run a household, also recreational facilities for families, and comprehensive and preventive health services for women. Dr. Sokolowska pointed out in one of her publications that family responsibilities are three fold: Firstly, the biological fact of maternity, which is not transferable from women; secondly, the social aspects of maternity, such as the education and care of children, which are certainly transferable and sharable between women and men; thirdly, housework and the maintenance of the home place, which also are certainly transferable and sharable between women and men. Women must begin to recognize that they can share the social aspects of maternity and housework responsibilities and they should begin to transfer these in equitable fashion, not only to their spouse but also to all other members of

the family. As new patterns are evolving for the individual development of women, the changing role of the children and the spouse must be fostered. Duties and responsibilities within the family have to be shared not merely among the adults but among the children also. For women, social change, control over their own fertility, and the gradual passing of the authoritarian, male-headed family structure mean a wider range of choices and greater status in decisionmaking not only at home but in the health care field or wherever they are employed. As women find themselves playing the role of wife, mother and worker, they desire and need more assistance with housework and child rearing which can be shared. Moreover, the emerging picture of the woman at home is that she is determined to participate in decisionmaking in matters of concern both within and outside the home. These changes demand a fundamental change in the relationships and behavior of all family members. My spouse and children now say such things as, "Let's cook dinner for us" instead of saying, "Let's cook dinner for Mom tonight".

Even though various scattered data show conclusively that things are still not so good for women politically, socioeconomically, educationally, in the labor force, and in personal life, recent years have witnessed major developments which are tiny steps in the right direction. These are, firstly, the militant universal resolve of increasing numbers of women (and men) that they will no longer be shut out from the political, economic and social life of their times and, secondly, the growing awareness of governments that a healthy modern society cannot continue to waste human resources by discrimination on the grounds of sex (or economic or social class, or ethnic or minority status, either).

Our world is certainly less of a man's world today, but it is still not yet a people's world. Even in many nations where legislation requiring equal rights and responsibilities for women has been around for many years, the process has been slow. Lest we become discouraged too soon, we should not overlook the underlying importance of the time factor in the emergence of changes for the better in the status of women in health care decisionmaking positions. In time, as their numbers, skills, assertiveness, and socioeconomic power increase at all levels, women will achieve equal status in decisionmaking in the health care field.

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Analysis of the Role of Women in Health Care Decisionmaking

A U.S. Response to a Look at Poland
The Class Nature of Decisionmaking Among Women

Judith Ann Spelman, R.N.
Member, Bay Area Negotiating Council
San Francisco, California

I have spent six and one-half years actively involved in the "Women's Movement", particularly the women's health movement. I have seen a number of changes which have been important to women—changes that have improved the material and psychological well-being of large numbers of women. Examples are the legalized right to abortion in the United States and improvements in availability of safe abortion procedures. Another change, well represented at this conference, is the advancement of individual women to prominent positions in government, university and hospital hierarchies. Perhaps the most significant change has been the generalized recognition of the problem itself so that, for example, universities have special admission procedures for women and governments sponsor conferences such as this one.

Underlying these needed changes that our generation has seen and in fact created is a problem more basic than the question of the status of women in the health sector or any other sector. This is the problem of class.

Dr. Vincente Navarro has documented the problem of class as it affects women in his article, "Women in Health Care" which appeared in the *New England Journal of Medicine* this past February. He stated that "the occupational, class and sex structure of the United States health labor force is similar to the competitive sector of the economy, (i.e., it is predominantly female, poorly paid and poorly unionized). Upper-middle class men compose the great majority of medical professionals, whereas lower-middle and working class women form the greatest proportion of all middle level, clerical and service workers. The division of labor is due to the role of women both in the family and as a reserve of labor for the economy. There is a virtual absence of the majority of producers—the lower—middle and working class women—in the decisionmaking bodies of the health institutions". While it is true that some individual women have risen to positions of prominence, their decisionmaking nonetheless represents the interests of the upper and upper-middle classes from which they come.

It is my contention that the problem is not whether a man or a woman writes a piece of legislation, or whether a man instead of a woman performs an abortion, or whether a woman instead of a man owns a large manufacturing company. The problem is not whether men or women hold such positions of power but in whose interests such concerns are run, in whose interests the decisions are made. And it must be asked who benefits from it, who pays for it, who profits from it? There is no certainty whatsoever that decisions will be made in the interests of the majority just because women are making the decisions.

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The Class Problem in the Health Sector

Theoretically the class problem has three parts: first, a relatively small number of people (some of whom are women) control important decisionmaking that affects large numbers of people; second, decisions are based on self or class interests, not on the interests of the majority of people; and third, while their predominant upper class interests are the maintenance of power and of the profitability of the businesses, these are not the predominant class interests of the majority of people.

I think in our society it is no secret that the profit motive underlies most decisionmaking: It at least dominates overall planning in the private sector.

In the national sector public decisionmaking is dominant by concern with maintaining state and international power and prestige. Other factors, such as strong labor union movements and new scientific advances affect the technical aspects of plans. When profit and power underlie decisions it makes little difference whether they are made by men or women. Despite the fact that women can be found in certain decisionmaking positions throughout the economy today, their presence has not appreciably affected such deplorable conditions as drugs marketed before adequate research has been done, understaffing that exists in most of our hospitals, or the absence of childcare facilities in major public and private hospitals. Yet, it is precisely these kinds of conditions that must be changed before we can say that there has been a real improvement in the status of all women.

This is not to say that men and women decisionmakers are not aware of these problems. They are, but, in the end, the cost of their decisions in terms of money

will be the overriding factor and not the cost in terms of human welfare. Unfortunately, this has been proved to me again and again and I would like to give some concrete examples.

One year ago at this time I was walking a picket line in San Francisco. I was one of 4,400 registered nurses who had gone on strike against 40 health care agencies in the greater Bay Area. The strike was a drastic step for a group of health professionals with direct patient care responsibilities.

The main issues of the strike were understaffing and the use of untrained personnel in specialty units. The registered nurses felt that conditions in hospitals constituted a real danger to patients and themselves. For us as workers such conditions meant exhaustion, guilt, poor performance and lack of job satisfaction. We
152 asked for a voice in decisions that determined staffing on an overall as well as a day to day basis. We felt that our voice was necessary in these decisions because we were familiar with the actual conditions on the floors and in the clinics. The administrators who actually made the decisions tended to be far removed from the everyday problems and dangers of both the nurses and the patients. We also asked that only registered nurses with appropriate training be sent to specialty units such as renal dialysis, cardiac care, intensive care nurseries, burn units and emergency rooms. In most of the hospitals this was not the case. We asked the hospitals to provide inservice education to ensure that a pool of adequately trained nurses was available to function in those units when the need arose.

This was a strike that affected large numbers of people, many of whom were women. This was also a strike that involved a lot of money, in actual and potential "losses" to the hospital as well as missed wages. Many people involved in the decisionmaking that settled the strike were women. This female preponderance did not automatically mean that decisions were made to benefit the people who worked in and used the involved institutions. At the hospital where I work, for example, the director of nursing who is also the assistant administrator of the hospital is a woman; the director of public relations is a woman; the acting director of personnel is a woman, one of the most active attorneys representing the hospital is a woman. The supervisors who on a day to day basis made and enforced the decisions to send unqualified personnel to the specialty units were all women. Most of the striking nurses were women and many patients were women.

The dangerous situations that had occurred as a result of understaffing had been diligently documented by the nurses. Many concrete examples had been set down on paper for examination. The hospitals claimed that the nurses were lying. One hospital first denied the charge of improper staffing in intensive care units but when the evidence was in it was later reluctantly forced to admit to such staffing in the case of "emergencies". (A nurse from the intensive care unit of this hospital felt so strongly about this matter that she made the following statement to the press: "If Mt. Zion does indeed assign untrained nurses to specialty care units only in emergency situations then these areas are in a constant state of emergency.")

The hospital managements stated that decisions about staffing were theirs and theirs alone. They claimed that costs of certain changes were prohibitive. They said too much money had already been lost during the strike and they did not intend to lose more.

So it seemed that our demands for safe patient care and job satisfaction were very expensive. An adequately staffed hospital would not be a profitmaking hospital. The women as well as the men in decisionmaking positions in the hospitals turned out to be first and foremost defenders of the financial status of the hospitals and not the defenders of the needs of patients and nurses. It was a sad lesson to learn.

To move to a more current example, this conference manifests the same kind of class problem. This is an international conference on women in health, but who here truly represents the day to day interests of the large numbers of women from the lower middle and working classes? Who here works every day in a hospital dietary or laundry department? Who here has worked for ten or fifteen years as a nurse's aide or licensed vocational nurse on the same floor in the same hospital as so many women have? Who here uses Medicaid or Medicare to pay her medical bills? Who among us relies on a slim Social Security benefit to pay the rent and buy the food?

The fact is that the majority of workers in and users of the health care system fall into categories such as these—non-professionals who make low salaries and have little decisionmaking power in their jobs. It is the condition that this majority faces that most demands remedy. The women who most need a voice and representation are not here today. We cannot represent them from the prestigious positions that we hold.

I must conclude that the promotion of individual women to positions of prominence does not constitute a significant change in the status of women. The advances of upper or upper-middle class women still leaves us with the same class structure underlying the condition of women. The class structure is still more powerful than the sexual factors and it still leaves the interests of a majority of women unrepresented in the most powerful places of decisionmaking.

Action that will alter the course of the class nature of decisionmaking must begin now. Therefore, in concert with some other conference participants, I would like to put forward a list of minimal changes required to make a dent in the problem.

*Health care must be delivered in a system where patient and worker needs, not company profits are unquestioningly accepted as the priority.
*All health care institutions must be controlled by the workers in those institutions and the people who use them.
*Day care must be provided at all places of employment and housework must be paid for.

*An aggressive national program must be instituted to recruit and retain women of color into health science schools. Opportunities for education and career advancement must be easily available for all middle and working class women who seek them.

*On the job time must be allowed for workers and patients to discuss problems and create solutions. This would require adequate staffing in all institutions.

Frankly, I do not expect that such conditions will be legislated into reality, for it would mean legislating the current economic system into oblivion. I expect the groundwork for these changes to be laid by grassroots organizing among working class people. Leadership for these struggles will come from working class people.

In conclusion, I would call on each of us here today to examine very carefully which interests we as individuals represent. We must then devise ways to associate ourselves with the interests of the majority of working people and out patients, and not with the class interests of health care businesses. Then we will have begun the real struggle that will lead to the advancement of women.

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Analysis of the Role of Women in Health Care Decisionmaking

A Look at the Philippines

Aurora P. Asanza, M.D.
Assistant Professor of Pediatrics
College of Medicine
University of the East
Quezon City, Philippines

There are no significant factors that distinguish the role of women from that of men in making health care decisions in the Philippines. That is as it should be. Inclusion and participation in health care delivery, particularly in making key decisions, are based solely on standards of professionalism. This means that, regardless of sex, positions in health care delivery in the Philippines are earned by one's degree of competence in a chosen field.

Societal realities in the Philippines demonstrate the validity of these statements. The Philippines is a country of 7,100 islands forming a homogeneous archipelago. It is a nation of 40-odd million people. It has been termed, in socioeconomics parlance, a developing nation. The implications of being a developing nation are manifold but the dominant inference is that the Filipino people are trying to harness all the resources at their disposal to enhance the quality of their life. Such an undertaking is a veritable struggle. This becomes clear when you consider that whatever gains made in the direction of development are just as soon negated by the continually increasing demand of an, as of now, uncurbed population growth on the country's limited resources.

To succeed in this national task is not even an option. It is an imperative. For failure is tantamount to national destruction. The margin of success and failure ultimately depends on how effectively the nation is able to harness her human resources. It depends on the extent of the active participation, quantitatively and qualitatively, of her people. Because of this, it is obvious that, as far as quantity is concerned, women cannot afford to take a back seat in the drive for development. Rather, they must be in the vanguard. To do less would be like tackling a job with one hand tied behind the back and, considering the high stakes, such a strategy would be suicidal.

Happily, Philippine culture readily lends itself to a full participation of women in the developmental process. Way back during the area of "barangay" Philippines, women had already enjoyed an equal status with if not superior to men. Ancient codes which have been preserved reveal, for example, that ownership of land, a cherished prerogative in an agricultural milieu, was equally the right of men and women. Teodoro A. Agoncillo, noted historian, writes:

"Women before the coming of the Spaniards enjoyed a unique position in society that their descendants during the Spanish occupation did not enjoy. Customary laws gave them the right to be the equal of men, for they could own and inherit property, engage in trade and industry, and succeed to the chieftainship of a *"barangay"* in the absence of a male heir. Then, too, they had the exclusive right to give names to their children. As a sign of deep respect, the men, when accompanying women, walked behind them."

Three hundred years of Spanish rule, however, cannot but make a difference. Nevertheless, even during this era, women did not become completely subordinated to men. The Filipinos' struggle for independence attests to this. Its history is replete with women who played leading roles (even led military uprisings) against foreign domination. Even today, the Philippines is still largely a maternalistic society. In the rural areas which constitute a major portion of the country, it is still customary for males to give the parents a settlement in terms of property and/or service to the parents of a girl whom he intends to marry. It is also the duty of the man to shoulder all the expenses incidental to the wedding, including a lavish feast.

Thus, the active role of women in national development and, by deduction in health care delivery is ensured. For today, the Philippines is turning more and more to the rich heritage of its past in search of cues to meet the challenge of the future.

Indeed, health care delivery is a vital component in this struggle for national development. Obviously, a weak, unhealthy people cannot be expected to deliver and to participate in the same level of quality as a strong and healthy people. Such a realization has dawned on the nation's policymakers. It is not surprising then that health care delivery has been identified as one of the major strategies for development.

It is propitious then that there is wide involvement of women in health care delivery. This can be traced to two related factors. The primary factor is the premium placed on education by Filipinos. The most cherished dream of Filipino parents is to be able to send their children to school and have them become professionals. It is not strange that some families live frugally and even sell land and belongings in order to support a son or a daughter through the university. But why the preponderance of women in the health field? This is due to the second and related factor.

Some sort of sex role stereotyping has dictated that the acceptable fields of higher study for women be either in the teaching profession or in the medical and related professions. Thus, many women who pursue higher studies eventually wind up as doctors, nurses, medical technicians, pharmacists, nutritionists, etc.

Note that education is a function of competence and, by extension, of appointment and advancement to key decisionmaking positions in the health care hierarchy. The entry of women is limited especially in the line of specialization. Opportunities at specialization are, however, equally open to men and women.

In the Philippines the Department of Health (DOH) is charged with the function of health care delivery. The Department is headed by a Secretary with a cabinet portfolio. It is administratively divided into bureaus
156 which are further subdivided into divisions and in turn into sections. The Office of the Secretary is in charge of formulating national policies and seeing to it that the bureaus which function autonomously pattern their programs in line with the policies. The bureaus are headed by directors who interpret national policies into concrete programs of action for their specific areas of coverage. The directors supervise the divisions under them.

A division is headed by a chief who oversees the work of the sections detailed to the division. Decisions at this level involve the formulation of strategies in line with the concrete programs of action drawn up by the Bureau Director. The successful implementation and evaluation of these strategies also fall under the responsibility of the division chief.

Advancement in this health care hierarchy up to the level of division chief is done via standard civil service procedures which depend on tenure, experience, and prescribed qualifications. At the levels of Secretary and Bureau Director, appointments come from the Office of the President of the Republic. This implies that getting the post of Director or Secretary becomes dependent on how a prospective appointee has come to national prominence and/or on the degree of his acquaintance with people who can influence the outcome of appointments.

An analysis of this health care hierarchy reveals that up to the level of division chief, women occupy decisionmaking positions. The posts of Secretary and Bureau Directors, however, still remain an exclusive male province.

There are special health care programs, designated as projects, that are headed by project directors at an equal level with bureau directors in the health care hierarchy. The decisionmaking process and the attendant responsibilities at this level are also comparable to the bureau level. Here women have come into their own. At present, there are two females Project Directors heading the Family Planning Program and Nutrition Program.

Focus on a particular female division chief will perhaps serve to illustrate the foregoing discussion. Dr. Amancia Angara is the head of the Maternal and Child

Table 1: Philippine Physicians Registered With the Board of Medical Examiners, by Year of Registration and Sex: Selected Years, 1930-69

Years of registration	Both sexes	Male	Female	Percent female
Before 1930	2,555	2,490	65	2.5
1930-34	1,093	1,041	52	4.8
1935-39	1,599	1,330	269	16.8
1940-44	1,433	1,055	378	26.4
1945-49	1,060	748	312	29.4
1950-54	1,831	1,327	504	27.5
1955-56	3,811	3,917	1,884	32.6
1960-64	6,888	4,124	2,764	40.1
1965-69	7,150	4,039	3,111	43.5

Table 2: Cumulative Number of Registered Philippine Physicians: 1930-1970

Year	Male	Female
1930	2,490	65
1935	3,531	117
1940	4,861	386
1945	5,916	764
1950	6,664	1,076
1955	7,991	1,580
1960	11,908	3,474
1965	16,032	6,238
1970	20,071	9,349

Table 3: Philippine Physicians, by Principal Employee

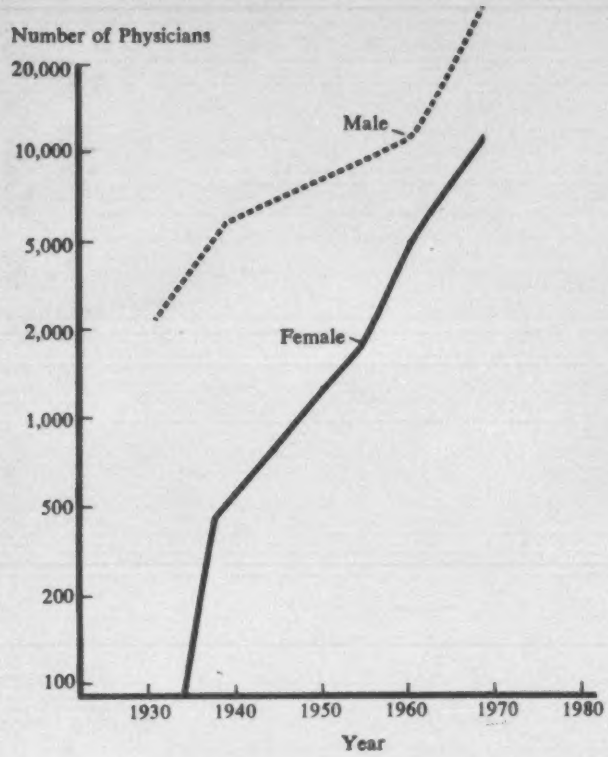
Principal Employer	Number	Percent	
Total	7,519	100.0	
Self-Solo Practice	2,860	38.0	
Self-Group Practice	176	2.3	
Medical School	252	3.4	
Department of Health	2,462	32.7	
Department of Education	58	0.8	
Department of National Defense	35	0.5	37.8
Armed Forces of the Philippines	71	0.9	
Other Government offices	221	2.9	
Private Hospitals	270	11.7	
Private School (Non-Medical)	44	0.6	
Private Industries	149	2.0	
Voluntary Medical Organization	23	0.3	
Other Organizations	77	1.0	
Completely inactive	215	2.9	

Health Division. Her ticket to this post is a Ph.D. in Maternal and Child Care from Harvard University. Dr. Angara feels that the post should logically be filled by a female. She adds, however, that her appointment was made not because she is a woman but because she was the most qualified for the post. "If there were a man more qualified, I'm sure he would have gotten the post instead of me."

It would be well to reiterate that there are no significant factors which distinguish the role of women from that of men in making health care decisions in the Philippines. However, women can claim (and with justifiable pride) that, on a professional basis, they are on equal, if not superior, footing with men.

Although this is true, not many women take advantage of this opportunity. Reasons for this are: one, culture, in the sense that they still feel that their place is the home; and proliferation of domestic help in the

Figure 1: Cumulative Number of Registered Physicians



Philippines so that women are free from household chores to engage in jobs outside the house.

I would like to address myself at this point to some of the discussions earlier in the conference. One was that physicians are more concerned about disease than people, and secondly, that they do not give due recognition to the roles of other paramedical help.

In the Philippines, the nurses and the paramedical help are also suffering from medical chauvinism. There are no easy answers to this problem; however, I would like to share with you what we are trying to do in my university. We feel that since all of us working in the health care system have one objective, that of caring for humanity, perhaps in our training we should be exposed to each other more. Thus, the newly established National Teacher Training Center of the Philippines is trying to develop programs in the training of teachers in the health care system to be exposed to each other early, so that the barriers to each specialization will be broken down, and so that in the medical school and in the medical center, the teaching of health care delivery would be truly a team approach. 157

In the past, like most of us here, the Philippine doctors have been concerned mostly with the teaching of knowledge only to their fellow physicians. They have forgotten to teach attitudes, and we realize that there are a lot of attitudes among physicians that we have to change if we are to improve the health care delivery system everywhere.

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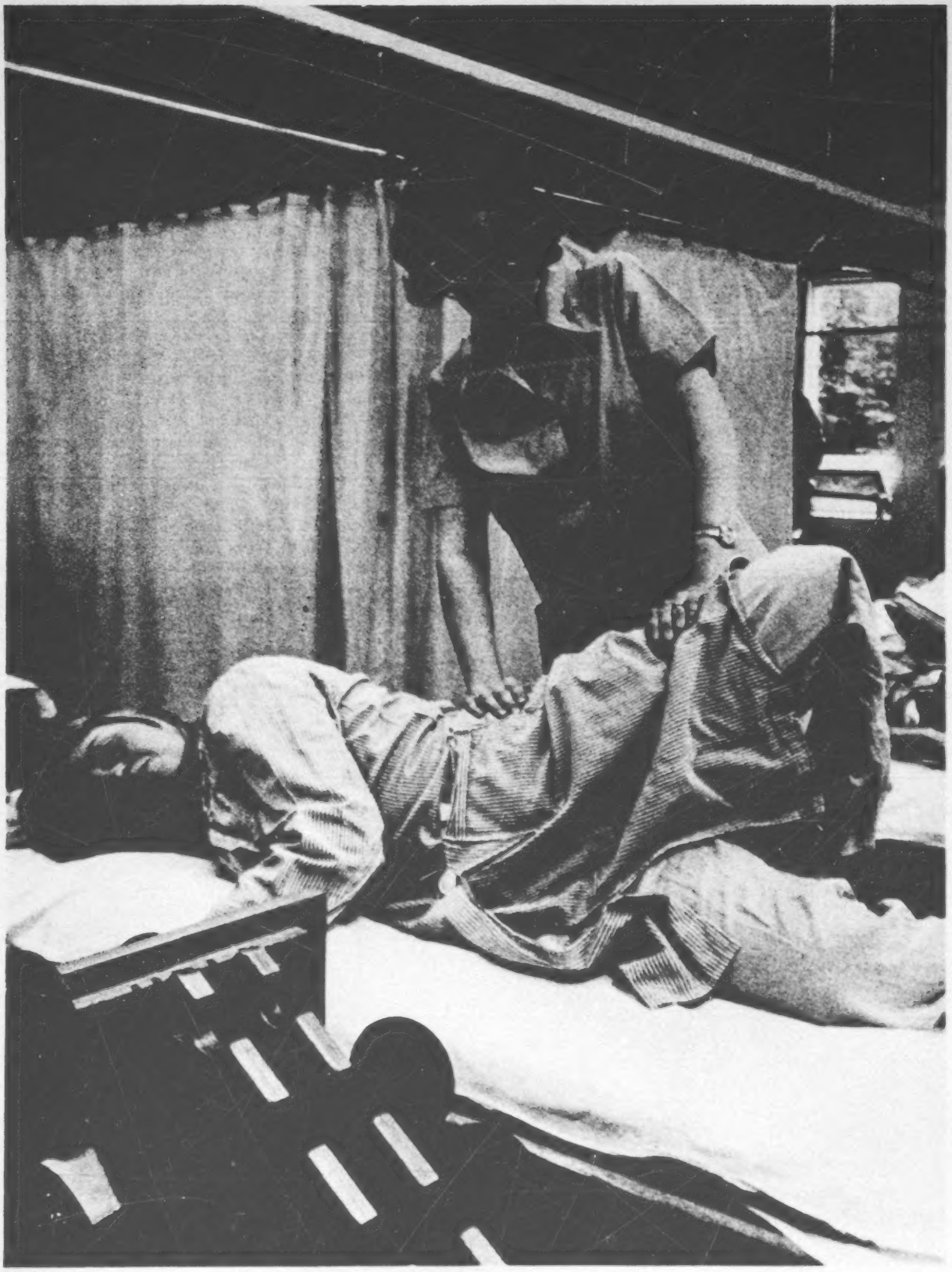


Analysis of the Role of Women in Health Care Decisionmaking

A U.S. Response to a Look at the Philippines

Betty M. Vetter, M.A.
Executive Director
Scientific Manpower Commission
Washington, D.C.

The status of Filipino women as decisionmakers in the health care field, as Dr. Asanza has outlined for us, can only make us wish women had reached a similar level of equality in the United States.

Although you have heard much earlier in this conference about the status of women in U.S. health care, it might be useful to review a few of the U.S. statistics that can be compared with those of the Philippines that she has given us.

For example, she has shown us that between 1965 and 1969, 43.5 percent of the new physicians registered in the Philippines were women. By contrast, 7.5 percent of the U.S. medical graduates in 1968-69 were women, and that proportion rose only to 11 percent even in 1974. In 1971, only 10 percent of the clinical specialists in our U.S. medical school faculties were women, and the proportion of women in medical practice ranged from about 20 percent in pediatrics down to 2 percent in surgical specialties, averaging about 7 percent overall. Women M.D.'s in the United States are conspicuously absent in the highest paid and, therefore, the dominating specialties.

Further, a 1970 survey noted that approximately one-third of the practicing U.S. women physicians in that year were foreign trained, compared to less than one-sixth of the men practicing in this country.

We do see some improvement ahead in these proportions. The entering medical class in 1973-74 was 19.7 percent women. In 1974-75 it was 22.2 percent. Total enrollment last year was 18 percent women in medical schools. So the proportions are increasing.

Why is it so important that the proportion of women M.D.'s increase if women are to have an equal opportunity to share in health care decisionmaking? Our staff of registered nurses is, after all, 95 percent women, as it probably is also in the Philippines. By sheer weight of numbers, women thus provide more than half the actual health care given to all patients. The answer in the United States is a very simple one. Nurses are not *allowed* to make even simple policy decisions about patient health care in any case where a doctor is involved.

What factors in the Philippines have brought about this much higher participation of women at the decision-

making level; that is, as M.D.'s? And does this greater participation mean in that country what it might mean in this country, and if it were true, would decisionmaking might then be expected to be shared in approximately the proportion that women qualified as M.D.'s?

As Dr. Asanza has shown us, the higher participation of women is partly due to her nation's need to utilize all its human resources in enhancing the quality of life; and partly because health care is a "traditional" woman's field.

But here, the difference may lie in the use that is made of trained women. We, too, have assigned the role of nurse principally to women, but U.S. nurses can hardly be said to make major health care decisions.

In checking a list of "expert witnesses" who have appeared at some of the Congressional hearings on health care legislation over the past three years, I found the list to be curiously devoid of nurses. Indeed, there were only two women physicians that I found in going through about seventeen sets of hearings. And, of course, the legislative health care decisions made in the United States are made by men. Only 3.3 percent of our Federal legislators are women, and there are none in the Senate.

Dr. Asanza suggests that the long heritage of Filipino women prior to the coming of the Spaniards may also have been influential in the participation of women in decisionmaking positions. While this may be true, it seems more likely that the 300 years of past Spanish influence led by the male-dominated Catholic church and the military probably would be a stronger influence.

We may also be misinterpreting the meaning of the statistics from the Philippines to indicate more participation in decisionmaking than may really exist. She has shown us certainly that women are widely involved in the delivery of health care in the Philippines. She hasn't told us as much about the amount of decisionmaking that takes place below the top two levels in the Department of Health, which are posts held by men. She has not told us what proportion of division chiefs are women, nor of section heads. She did tell us there are two women project directors, but

out of how many total? So perhaps the situation is not as truly equal as it seems.

But even if this is so, Filipino women seem to be ahead of U.S. women as participants at the decision-making levels in health care. We do show some signs of progress. Some of our sex stereotypes are changing. Certainly more women are entering medicine and a few are moving into the highest paid specialties long dominated by men.

Do Filipino women make up a substantial proportion of surgeons, or are the medical and health care areas where women are most likely to specialize those that are lowest in pay and lowest in prestige, as in the United States? These are all factors to examine if we are to try to provide the women engaged in health care in any country with equality of opportunity for decision-making.

What can we emphasize in the Filipino experience to carry into our own efforts to include more women at this level in this country? I suggest the most important thing to be emphasized again and again and again is that we can no longer afford the wasteful luxury of failing to utilize the brain power of half our population—talented, competent, trained persons of both sexes are the wealth and the promise of every nation, not only in health care but in all human endeavors.

No nation on earth, including specifically the United States, is wealthy enough to waste even a part of the ability and training of half its population.

The decisions are much too difficult and too complex for men to handle by themselves. But this truth is less widely understood today than it was even in our pioneer days. Women stand ready to share again the hardships, the hard work, and the dedication. We are ready also to share the responsibilities of decision-making. Gradually men are recognizing how easily such burdens can be shared. The world doesn't collapse and they don't lose effectiveness. We women all know that. But we must help them as they learn that truth as well.

Table 1: Applicants and Admissions to Medical School By Sex for Selected Years

First-Year Class	Men			Women			Women as Percentage of Total Accepted
	Number Applicants	Number Accepted	Percentage Accepted	Number Applicants	Number Accepted	Percentage Accepted	
1929-30	13,174	6,720	51.0	481	315	65.5	4.5
1939-40	11,168	5,890	52.7	632	321	50.8	5.2
1949-50	23,044	6,750	29.3	1,390	400	28.8	5.6
1959-60	13,926	7,968	57.2	1,026	544	53.0	6.4
1966-67	16,554	8,267	49.9	1,696	856	50.5	9.4
1967-68	16,773	8,718	51.9	1,951	984	50.4	10.1
1968-69	19,021	9,116	47.9	2,097	976	46.5	9.7
1969-70	22,176	9,536	43.0	2,289	1,011	44.2	9.6
1970-71	22,253	10,203	45.9	2,734	1,297	47.4	11.3

Source: *Women in Medicine*, by Marjorie P. Wilson, Unpublished paper from The Conference on Women in Science and Engineering, National Research Council, June 11-12, 1973

Table 2: Woman Students and Woman M.D. Graduates in U.S. Medical Schools for Selected Years

Year	No. of U. S. Med. Schools	Total Enrollment	Woman Students		Total M.D. Grads.	Woman Graduates	
			No.	% of Total		No.	% of Total
1914-15	96	14,891	592	4.0	3,536	92	2.6
1924-25	80	18,200	910	5.0	3,974	204	5.1
1934-35	77	22,888	1,077	4.7	5,101	207	4.1
1944-45	77	24,028	1,352	5.6	5,136	262	5.1
1954-55	81	28,583	1,537	5.4	6,977	345	4.9
1964-65	88	32,428	2,503	7.7	7,409	503	6.8

Source: *Women in Engineering, Medicine and Science*, by Vera Kistiakowsky, The Conference on Women in Science and Engineering, National Research Council, June 11-12, 1973

Table 3: Applications, Enrollments, Graduates, U.S. Medical Schools, By Sex, 1968-69—1973-74

YEAR	APPLICANTS			FIRST YEAR ENROLLMENT			TOTAL ENROLLMENT			GRADUATES		
	Total	Women	% Wom.	Total±	Women	% Wom.	Total±	Women	% Wom.	Total	Women	% Wom.
1968-69	21,118	2,097	9.9	9,863	887	9.0	35,833	3,136	8.8	8,059	607	7.5
1969-70	24,465	2,289	9.4	10,422	948	9.1	37,690	3,392	9.0	8,367	700	8.4
1970-71	24,987	2,734	10.9	11,348	1,256	11.1	40,238	3,878	9.6	8,974	827	9.2
1971-72	29,172	3,737	12.8	12,361	1,693	13.7	43,399	4,690	10.8	9,551	860	9.0
1972-73	36,135	6,000*	16.6*	13,677	2,300	16.8	47,366	6,082	12.8	10,391	924	8.9
1973-74				14,124	2,786	19.7	50,716	7,824	15.4			

Source: *Minorities and Women in the Health Fields,* Bureau of Health Resources Development, Public Health Service, May 1974
* Estimated
+ Includes repeaters and those who re-entered

Table 4: Percentage Of All Physicians In Various Specialties Who Are Women

Specialty	% Women	Specialty	% Women	Specialty	% Women
Medical (total)	9.0	Surgical (total)	2.4	Other (total)	8.9
Allergy	6.6	General surgery	1.0	Anesthesiology	14.0
Cardiovascular	2.8	Obstetrics		Neurology	6.9
Dermatology	7.0	Gynecology	6.9	Occupat'l. Med.	3.1
Gastroenterology	2.3	Ophthalmology	3.2	Pathology	11.6
Internal Medicine	5.4	Orthopedic	0.5	Psychiatry	12.5
Pediatrics	20.3	Otolaryngology	1.0	Physical Med.	15.2
Pulmonary	8.0	Plastic	2.7	Preventive Med.	12.1
General Practice	4.2	Other surgery	0.4	Public Health	18.5
				Radiology	4.8
				Other	7.4

Source: *Goals for Women in Science,* Women in Science & Engineering, Boston, Mass., 1972

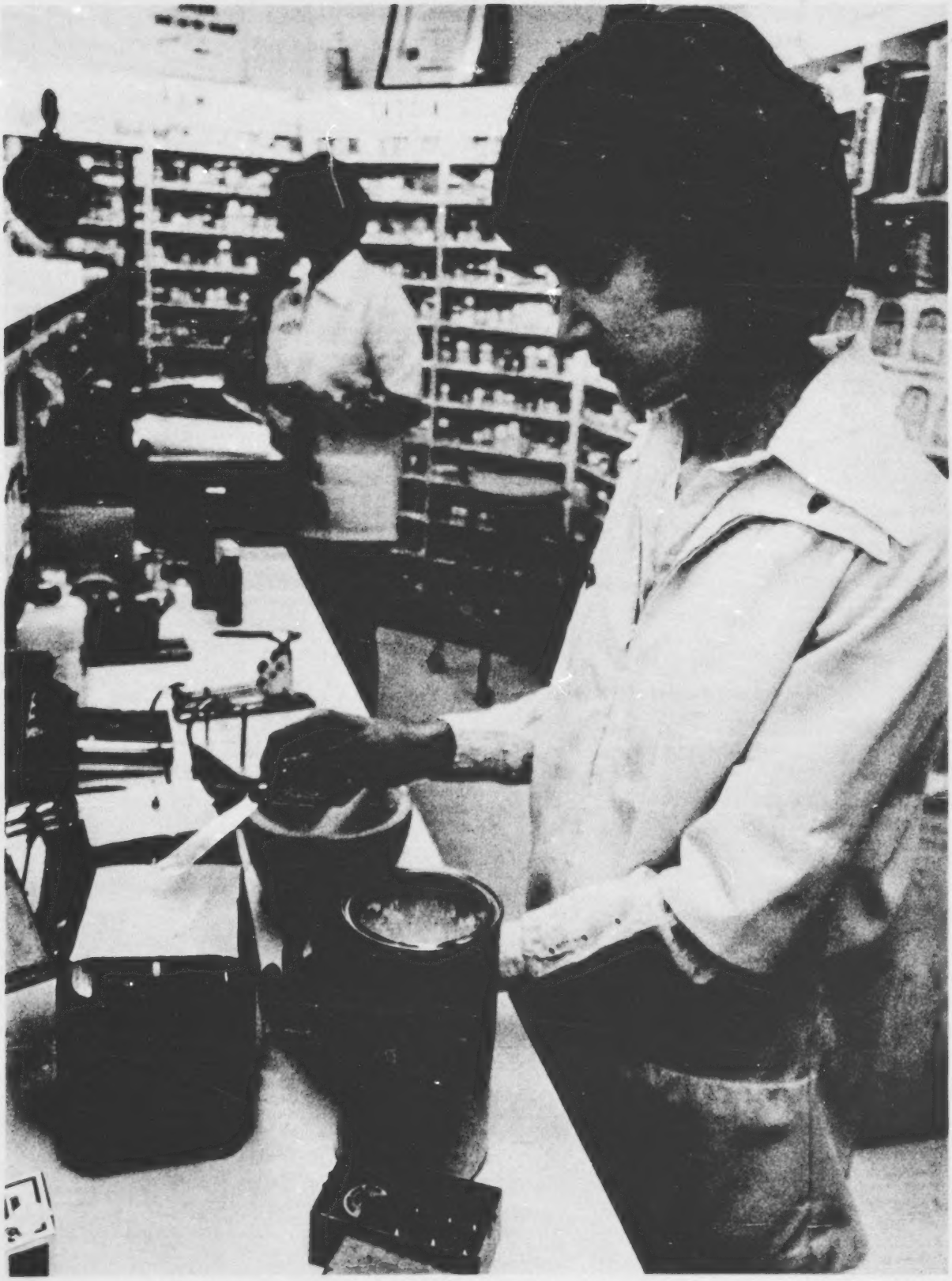
Table 5: Percentage of all Physicians in Various Professional Activities Who Are Women

Specialty	All	Office based practice	Hospital based practice	Other activity
General practice	4.2	3.6	9.6	7.7
Medical Specialities	9.0	6.4	13.5	10.9
Surgical Specialities	2.4	2.0	3.4	3.8
Other Specialities	8.9	8.1	9.7	8.9
TOTAL	6.7	4.6	10.5	9.0

Table 6: Distribution of Physicians Among Specialty Groups, By Sex, December 31, 1971

Specialty Group	Number of Women Physicians in Group	Percent of Women Physicians in Group	Number of Men Physicians in Group	Percent of Men Physicians in Group
Total	22,563[d]	100.0	296,136[e]	100.0
General practice	2,462	10.9	53,896	18.2
Internal medicine	3,242	14.4	54,617	18.4
Surgery	855	3.8	69,154	23.4
Obstetrics/gynecology	1,421	6.3	18,349	6.2
Pediatrics	4,247	18.8	15,671	5.3
Psychiatry	3,209	14.2	21,241	7.2
Radiology	754	3.3	13,585	4.6
Anesthesiology	1,655	7.3	9,902	3.3
Pathology	1,435	6.4	9,471	3.2
Other	3,283	14.6	30,250	10.2

[d]-Excludes 4,471 physicians (481 not classified, 3,539 Inactive, and 451 address unknown).
[e]-Excludes 21,653 physicians (3,048 not classified, 15,849 inactive, and 2,756 address unknown).
Source: Special Tabulations from Physician Records, 1971, American Medical Association.



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Analysis of the Role of Women in Health Care Decisionmaking

A U.S. Response to a Look at the Philippines

Helen Rodriguez-Trios, M.D.
Attending Pediatrician, Lincoln Hospital
Bronx, New York

Dr. Asanza has presented a convincing case for the preservation of tradition where the tradition means greater equality among the members of a society than would otherwise exist. It would seem that the customs of the Philippines have enabled women to achieve a higher status as physicians than in any other nation except the socialist ones. The women doctors are 31 percent of the total, six times that of Puerto Rico and four times that in the United States. Perhaps the fortunate fact of the resistance of the people of the Philippines to colonization by the Spaniards and by the U.S. has indeed helped to maintain and expand women's roles as equal members of the society.

Our own experience as a nation struggling for survival has been somewhat different.

Puerto Rico suffered an intense colonization by the Spaniards for four hundred years and just when we had achieved our greatest degree of autonomy, a new imperialist imposition took place, occupation by the United States.

An intensified exploitation affecting the economic, social and cultural aspects of our lives then began to determine our course as a people. Decisionmaking for us has thus been limited to safe acquiescence or to dangerous resistance to the colonial constraints. It is, therefore, only in the context of ourselves as a direct colony of the United States that I can describe some aspects of health care that serve to illustrate women's roles.

Throughout the description, as I share experiences as a student and teacher at the Medical School of the University of Puerto Rico, I shall attempt to address the questions:

—Who makes the decisions?

—In whose interests are the decisions made?

It is clear to me that it is not enough to speak; women's voices must cry out for the social changes that will guarantee rights for the majority of women and therefore, for most people. If we speak for privilege, be it our own or the ruling men's, we shall surely be drowned out by the clamor of our marching sisters.

Medical Education and the Health Services

In 1950, a medical school was established in Puerto Rico with the mandate to train generalists to serve the population. The long tradition of free medical care for two-thirds of the people by the Government had culminated in the establishment of a network of health care facilities that were regionalized, comprehensive, and which allowed the free flow of people from one facility to another. The emphasis of the system was on preventive care. Community based health centers with well developed ambulatory care programs were built and the integration of social services with health care needs attempted.

Side by side, or shall I say, back to back, there were private facilities serving the more affluent one-third of the people. The amount of money available to the private sector was three times that for the public system. The existence of these two systems and the contradictions engendered by this paradox between the national interests and needs and a superimposed social organization which is not designed to serve them, is typical of the Puerto Rican situation.

Thus, while a medical school was established for the purpose of training us for a public system rooted in the philosophy of preventive medicine, the same school was patterned after Columbia College of Physicians and Surgeons in New York with its rigid traditional curriculum. This school has recently graduated its twenty-first class. Since 1950 it has gradually increased from 50 to 120 students of whom 26 percent are now women.

The difference which this has made in terms of health care for the people and in terms of the overall structure of the health hierarchy may be inferred by enumerating some of the problems faced by the medical school and the public system it should serve. These problems are very similar to those in the United States. They follow:

1. Most graduates congregate in the metropolitan areas, mainly San Juan.
2. Eighty-five percent or more specialize and consider themselves "overtrained" for rendering primary care.
3. Through time the increased enrollment has drawn more and more students from the upper

and upper middle-class whose values are often inimical to those of public service.

4. Fifteen percent migrate to the United States where they seldom work where the people live who constitute the direly underserved half of our nation that is here.
5. The policies of limited enrollment force a yearly exodus to Spain and Latin America of a number of students twice as large as the number admitted. Just as the U.S. shows a singular inability to train its own people while importing physicians from the Third World, Puerto Rico is now also importing a growing number of other Latin American nationals. These are serving in many of the primary care centers of the island while the graduates of the
164 University of Puerto Rico remain in the more prestigious positions.
6. The values inculcated by the school are at variance with its avowed commitment to function within the framework of preventive medicine. Technical excellence is stressed, ability to make money admired.
7. Today many of the health centers which were truly the backbone of the system are barely staffed.

Because the conditions described are similar to those of many other countries I wonder how many of these problems are also faced by the Philippines. I understand from Dr. Asanza that they lose 30% of their doctors to the U. S., and many other health workers also.

The Position of Women

An examination of the position of women within these problem-ridden systems of medical education and health services shows that it is similar to the one we hold in the U.S. Women health workers are over eighty percent of the total yet only about two percent of the top echelons of doctors, health department functionaries, or administrative officers.

Although nurses are often the most stable and knowledgeable people in the primary care centers and as such often make decisions as to patient care, their role has never been sanctioned. They do not receive the training nor the rights to make the many decisions that they must. They are trapped in the dilemma of dedicated workers who clearly perceive health care needs, but are not provided the equipment to serve them. If anything, time has eroded most of the autonomy of nursing. Public health nurses and nurse-midwives are more and more becoming assistants to doctors in the institutional setting.

The mass of the health workers receive salaries which are eight to twenty percent of those earned by the salaried physicians.

In this inequitable system all women are affected as health workers and as patients. Even those who as doctors are close to the top of the hierarchy are conditioned or denatured by the lack of equality that is built in.

The feelings of anger and frustration of even the more privileged young women who are medical students are very strong. Several years ago we held a women's faculty and student meeting to plan for increasing enrollment and retention programs. From a staid beginning, the meeting quickly passed on to an emotionally charged session as one after another revealed her pain at the daily assaults on our womanhood and the survival process which forced us to cut off our empathetic feelings about patients and fellow workers. Some confessed to attempting adjustment by appearing as unfeeling as the men seemed, perhaps the most destructive of all paths as it involved much denial.

Some recalled that the medical school lecture on abortion began with the remark that abortions could be classified as criminal or medical and since there were few if any medical indications for abortion, thus the discussion would be limited to the complications of the criminal. A few derogatory remarks about the women who would stupidly risk abortions then followed. A poor preparation indeed for those who as interns would admit several women daily who had taken those very same risks. We were certainly little inclined or able to identify with our fellow women or to begin to realize the need to struggle for truly preventive measures.

It certainly seems that medical education and the health care system lack the perspective that women workers and women users can bring. It seems equally certain that the perspective requires a thorough restructuring and democratization of the decisionmaking process for that process to be operative.

This last becomes clearer as we examine the Puerto Rican experience with population control programs. It serves as a clear illustration of health care as an instrument of social policy and, therefore, an argument for the need to restructure at the policymaking level. The sharing of this experience becomes very timely as the population control programs becomes more strident in their propaganda. The *Family Planning Digest* of May 1972 ends an article on sterilization titled "Simpler Methods Boost Public Acceptance" with the statement that "As U.S. professional attitudes change, it is possible that we may see sterilization become as important in family planning in the 50 States as it already is in Puerto Rico." Since HEW has almost totally funded the population control programs in Puerto Rico for several decades, it may be useful to look at what may be in store for an increasing number of women in the United States.

The full scale program of population control in Puerto Rico begins in the mid-forties with the industrialization efforts that established much of the light manufacturing on the island. These concerns employ mainly women. Soon sterilization by tubal ligation became the principal modality of birth control and was offered free of cost throughout the government centers.

As of 1968 over thirty-five percent of Puerto Rican women of childbearing age were already sterilized.[3] Still the sterilization programs have been stepped up,

and as the economic crisis deepens, and the militancy of the people increases, have taken on a frantic quality. Dr. Antonio Silva, Assistant Secretary of Health for Family Planning recently stated that 5,000 women were sterilized last year, and that we may look forward to 6,800 in 1975.

What makes this incredible program possible is the full cooperation of a colonial government and the reality of the women's position within the colony. At present women are thirty-five percent of the total salaried work force and forty-eight percent of those workers engaged in industry. The development of job opportunities for women in a country with unemployment that has ranged from 12 to 30 percent even after the mass migration of approximately one-third of its people, has had profound effects on the structure of the family. The need for subsistence, the lack of child-care facilities, schools, social services, abortion rights, housing, and other elements to support family structure have driven many a woman to seek sterilization as a palliative. Many were not told that the procedure is permanent and fully one quarter exhibit regret.

The important point to underline is that women were not and still are not involved in these decisions that determine our personal and national future; these are made by the rulers of the United States; the U. S. corporations behind the U.S. Government which fronts for them.

In response women are fighting back. Many of us in and out of the health care field are reaching certian conclusions as to what it will take to organize our various sectors. We are gaining experience in struggle: The recently constituted Federacion de Mujeres Puertorriquenas is a sign of our recognition of the need to unite working women, housewives and students around a program of equal rights.

Cuba, curiously absent from this conference, has shown the way by developing a health care system that serves all of the people. Most importantly, it is a system that through the mass organizations incorporates the people themselves into being providers. We are very close to our sister republic, despite U.S. efforts to isolate us, and we watch with interest its struggle against sexism, surely the most effective as yet seen in Latin America and perhaps the world. Its beacon shines for all Latin Americans, no blockade can dim it.

Many of us are expanding our consciousness of how United States imperialism affects us and our sisters. We watched with horror its intervention in Chile where the model health care system is in shambles and our courageous surviving sisters and fellow health workers are still in the torture chambers. 165

Our understanding of the nature of U. S. imperialism grows day by day as we organize to end sterilization abuse, for family planning within the context of comprehensive health care, and for an end to profitmaking in the health system. All this converges on our struggle for full national liberation.

I wonder how much of our struggle for national liberation is shared by the people of the Philippines as it seems to me that we are fighting a common enemy. United States imperialism is the greatest enemy to the health of the world's people today.

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Statement

The Honorable Martha Keys

Congresswoman from Kansas
Member of the Committee on Ways and Means
Health Subcommittee
U.S. House of Representatives

I am deeply honored to be the representative of Congress at this all-important conference. As one of 19 women in the Congress and as the only Congresswoman serving on a committee having jurisdiction over health legislation, I am following the work of this conference very closely and look forward to assimilating and sharing with my colleagues the vast wealth of information which is presented by all of you.

My interest in health is deeply rooted. As the mother of four children, I have been the "organizer" of my family's health care system, so to speak.

Certainly, no health care legislation should be considered in the Congress which does not address the special needs of women nor weigh very thoroughly its effects on women. Women represent over half the population of the country. They are the largest consumers of health care, averaging 25 percent more visits per year to a physician than men. This figure would be greatly increased if visits to a pediatrician were to be included. Women take prescription drugs and are admitted to hospitals more frequently than men. Despite these figures, the health care delivery system is dominated by male physicians and the health care coverage offered by the private insurance industry favors men over women.

I would like to share with you some thoughts concerning the dual roles which women play in health care —first as recipients of care and then as providers of care—and the legislation before Congress which affects women in these roles.

Perhaps the most far-reaching health matter before the Congress is that of national health insurance. In six years, our national health bill has nearly doubled; in 14 years, more than quadrupled; and in the 24 years since 1950, increased by almost nine-fold. Our problems in the maldistribution of specialities among physicians and the geographical maldistribution of health manpower are well known. The financial leverage of a national health insurance system offers the real possibility of using financial incentives to promote efficiency in health care delivery and to redress the uneven allocation and distribution of health resources in America.

There are several national health insurance bills before the Congress. The Subcommittee on Health of 167
the House Ways and Means Committee on which I serve will soon begin consideration of these measures. Though each bill offers a different approach as to how such a system should work, common to the consideration of each of these bills must be how they will correct the inequities facing women under the present private health insurance system.

The coverage offered women by the private health insurance industry discriminates against women in many ways by limiting, if not completely denying, coverage for the health services women need most. Through their coverage, health insurance companies penalize women for their necessary physiological role. The two most glaring inequities relate to the lack of adequate and equitable coverage for pregnancy and gynecological needs.

Private insurance companies often charge women higher rates simply because they *might* become pregnant. Government surveys have shown that men and women lose almost the same amount of time from work due to acute disabilities—including the childbirth and pregnancy complications of women. Why then should women have to pay higher premiums?

It it standard procedure to make maternity benefits optional, requiring higher premiums, and employers often will not pay the extra amount. Even when extra premiums are paid, a woman must be enrolled in most plans for ten months before she is entitled to any benefits.

In some cases, female employees are denied maternity benefits on as favorable terms as the spouses of male employees. In testimony before the Joint Economic Committee, Ms. Barbara Shack of the American Civil Liberties Union pointed out that under some health insurance plans, maternity coverage differs from woman to woman, depending on her employment status. Under one plan, female employees were eligible to receive maternity benefits amounting to a flat rate of five days of hospital care and cash benefits of $300 for surgery and medical costs. The same plan permitted wives of male employees up to ten days of hospital care and a maximum of $100 in medical expenses! It is only fair to point out that this particular situation under this

particular plan existed two years ago; it may not now be the case. However, it demonstrates the point that women are indeed treated differently under the various health insurance plans, depending upon their marital status, not upon their actual health care needs.

Under the present system, there is inadequate preventive care for women. Almost 11,000 women die each year as a result of undetected cervical cancer. In many instances, these are needless deaths. The treatment and cures for uterine cancer in its early stages have been known for years. The Pap smear is a relatively simple diagnostic procedure and can readily determine whether a woman has or is developing cancer of the uterus or cervix. And yet, only a small percentage of American women actually receive this test each year. This can partially be accounted for by the lack of education on the part of American women. But economic reasons also impact heavily upon woman's decision to receive such a test. Many women cannot afford to pay $25 or more for an annual check-up with a gynecologist. Though such a visit is preventive in nature, its coverage is often exempted under private health insurance plans.

The Congress has already enacted legislation barring discrimination on the basis of sex in the areas of employment, education and credit. We must extend these provisions to health care and include in any national health insurance plan prohibitions against unequal terms and conditions of coverage based on sex.

In addition to the problems women face as recipients of health services, there are problems facing women as providers of care—the problems of women health professionals.

Really, we are talking about two problems. First, the need to eliminate sex role stereotyping in medicine, and second, to upgrade the professional status of those health professions which typically have been identified with women.

In simple terms, we must seek a more important role in the health care system for nurses as well as seeking to increase the number of women physicians and hospital administrators. About three-quarters of the nation's health care personnel already are women. The issue, then, is one of status.

The Federal Government is directly involved in this matter through Titles VII and VIII of the Public Health Service Act which govern health manpower and nurse training, respectively. Let me discuss briefly two bills before Congress—the Health Manpower and Nurse Training Acts of 1975.

Both seek to extend and expand existing programs. The nurse training bill has been approved by the House and Senate and will soon be considered by a joint conference committee. The manpower bill is ready for floor consideration in the House and will be scheduled for action very soon.

The Federal Government has been financing nursing education since 1956, initially in an effort to meet a shortage of nurses. Recently, however, the objectives have been broadened and instead of merely seeking to expand the output of the nurse training assembly line, we are trying to develop new professional skills and roles for nurses. The old idea that nurses are merely physicians' helpers must be ended.

The nurse bill before Congress proposes to spend $558 million over three years for nurse training, $225 million of this specifically earmarked for programs to upgrade the status of the nursing profession—advanced clinical specialty training, graduate degree traineeships, nurse practitioner programs, and other special projects. I am pleased with this bill and hope the President signs it into law.

I must confess, however, that I do have some reservations about the *man*power bill beginning with its name!

Only seven percent of the physicians in the United States are female, virtually the worst record in the Western World. And at the medical administration level, the record is even worse.

We have seen some progress. In the 1969-1970 school year, women comprised only 9.2 percent of the entering class in the nation's medical schools. Last year, women comprised 22.2 percent. This is progress, but obviously, we still have a long way to go.

Sex stereotyping cannot be abolished overnight by Federal edict. But Federal action can contribute to the solution. The increase in the number of women medical students came precisely during the period in which HEW started to enforce its nondiscrimination requirements. I am somewhat cautious about demanding that we go the "affirmative action" route in medicine, a path always fraught with the perils of backlash.

However, presently under Title VII Federal funds are authorized to promote medical education for minority and disadvantaged students. A similar effort should be made on behalf of women.

I have a few other reservations about the manpower bill. Under this legislation, the physician assistants program could conflict or compete with the nurse practitioner program. Further, the fact that most nurses are female and that most physician assistants are drawn from the ranks of male former military medical corpsmen, means that the Federal Government may actually be encouraging sex stereotyping.

Still, my biggest concern about the manpower bill is its lack of proper attention to the problem of women in medicine. It isn't so much that the bill is adverse to the interests of women, but rather, that the bill is neutral on the subject, and that simply isn't good enough.

In the end, the problems of women as providers and women as recipients of health care are merged. Without more women, making major medical policy decisions, or making key patient care decisions, the needs of women patients will never be fully protected.

I hope that through such vehicles as this conference, we can increase public awareness of these issues, an awareness that will extend to the halls of Congress.

Highlights of the Conference

Mary C. Howell, M.D., Ph.D.

Assistant Professor of Pediatrics
and Associate Dean for Student Affairs
Harvard Medical School
Boston, Massachusetts

There is a certain presumption in my task this morning of summarizing this rich and exciting conference. I have heard from many of you, speaking formally and informally, as individuals and in groups. But I certainly cannot pretend to represent a consensus. And in any case we must acknowledge forthwith that what I have heard has been filtered through my own set of interests and concerns, my own personal bias.

I will begin, therefore, at a personal level. As I sat down very late last night to collect my thoughts, my overwhelming impression was of our fantastic unity of purpose. In those moments when we have tilted into competition with or isolation from each other, the spectre of the present functioning of our medical care system has quickly brought us together again. And I for one am very grateful to have met here with you—some old friends, some new friends—to have shared common concerns and support, and to be reminded again of the wonderful potential of womanpower.

What we have heard from our sisters from aboard documents Barbara Ehrenreich's opening comment that we have no where to go but up. It is not only that women are the great majority of the underpaid and powerless health care providers in the U.S.; it is the very nature of our present institution of health care that brings us together. For despite the commonly heard avowal that we have a "non-system", it is clear that we are now working in a tightly controlled system based on competitive individualism and profit, which maintains its power, at least in part, by blaming its victims for their own misfortunes. And it really is a *medical* care system, for we have said over and over again that we are not allowed to attend to the health needs of those we serve. Against this background, what we have learned about other nations gives us some clues about the work we must do toward our shared goals.

Before I try to list some of those goals, I would like to make some general observations about meetings of women health workers. Mary Daly, the theologian, has observed that the universal oppression of women stands as a prototype, and that when we understand, in the gut, the nature of that oppression we are open to a sense of empathy with all people who are oppressed. Yesterday Ruth Sidel said it another way: "What's good for women is good for society as a whole". We were, after all, supposed to be talking about the conditions of our own work—but from the moment the conference opened it was clear that our primary concern was to be the welfare of our patients and the nature of the services that we provide for them. We are not predominantly interested in getting a "piece of the profit-and-power pie" for ourselves. We *are* desperately concerned about work settings, roles, and job structures that prevent us—and the many health workers, men and women alike, who are not represented here—from 169
providing humane, competent, caring, responsive services that promote health. When we have focussed on work issues—salaries, self-determination, full utilization of skills, inservice education and upgrading, collective bargaining, evaluation of performance by recipients of care, and an effective voice in policy—our intent has been to create work settings that would enable us to provide good care.

These are some of the goals that have concerned us:

Because we know that those who do not have access to health information are handicapped in their efforts to maintain and promote their own health, we want to share our health-related knowledge with layfolk: we heard a wonderful account of health education in Cameroon.

Because we acknowledge that the greatest proportion of health care is provided within families—by mothers and daughters and, we hope, by fathers and sons as well—we want to teach our caregiving skills in a manner that will decrease dependency on impersonal professional services.

Because we believe that it is obscene for anyone to make great personal profit, through earnings or investments, in the suffering of the ill, we want a national policy that prohibits profit-making in health care.

Because we have seen that costly medical services can destroy families we want public subsidies that guarantee the access to all services for all citizens.

Because we women know what it is like to receive health care services from alien and alienating providers, we want citizen groups to have a determining voice in the selection of health care trainees, including physicians, on the basis of demonstrated ability to provide empathetic care: we have heard about one model for this process, in China.

Because we know about the harm done to our sisters and others, in the U.S. as well as in Puerto Rico, as the result of irresponsible experimentation, unsafe medical devices and drugs, and unnecessary surgery, we want regulations that require fully informed subject and patient consent and participation in decisions about personal health.

Because we have seen that pushing highly credentialed token women into showcase jobs sometimes co-opts those women, and sometimes results only in token jobs, we want our cause represented in positions of policy determination by women from our ranks, empowered by our constituency: we have heard of such success from Australia.

Because we know that our training in health care does not prepare workers for primary care oriented toward the prevention of disease and the promotion of well-being, we want to redirect that training, as we have heard is done in the Philippines.

Because we have personally shared the discomforts of inappropriate and neglectful health care services for mothers and their children, we especially want to redirect the manner in which that care is provided: we have heard about such programs in Sweden.

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Because we have learned that large bureaucratic agencies for health care delivery demand that workers respond to administrative demands rather than to patient needs, we want health care work to be done in smaller decentralized units that ensure that providers and recipients of care have direct personal contact with and responsibility to each other: we have heard about such an arrangement in Colombia. Finally, because most direct health care services in the U.S. are provided by women, we want recognition of that reality in policy determination, as is the case in Russia, Finland, and Poland.

These are general goals: they are—I am an optimist—our five-year plan. For today, we have also voiced some immediate recommendations directed to the Department of Health, Education, and Welfare:

(1) *With regard to research:* there is an urgent need for research funding for projects directed to problems formulated by women and carried out by women and until now relatively neglected. I have heard mentioned, as examples, the problems of occupational (or workplace) hazards; safe contraceptives for men and for women; our national inability to promote adequate nutrition by the distribution of the food we have; protection of our children from two of their greatest health hazards, accidents and environmental pollution such as lead poisoning; special problems in women's health such as vaginitis and repeated urinary tract infections; and our massive national problem of interpersonal and institutional violence. We recommend, as a start, that HEW establish an advisory board of women health workers and consumers—women who are identified with women—and through this board begin to solicit proposals for this non-traditional research.

(2) *With regard to programs:* our hopes of discovering or inventing models for the provision of decent and humane health care services demand the support of programs devised and directed by women. I have heard of plans for health centers collectively administered and controlled by a coalition of workers and recipients of care; for the exploration of new roles of health workers in the provision of primary care; for homebased and neighborhood-center based care; for childbirth services for (revolutionary concept!) low-risk pregnancies; and for support for the function of all care-providers as teachers of health-related knowledge and skills. As with research, we women might even claim some reparations, in dollar amounts, for our past lack of access to funding for these and similar projects that concern us so deeply. Again, as a first step, an advisory board of women who are identified with women could solicit project proposals if HEW were to allot funding.

(3) *With regard to affirmative action programs:* it has been said, at this conference and elsewhere, that women identified with men are not easily able to promote the causes that we have voiced at this conference as common concerns of women health workers. But, in fact, affirmative action programs have so far encouraged the hiring and promotion of women who have learned to identify with men as a survival mechanism, and who are, therefore, the persons most acceptable to the male establishment. At a minimum, the following changes have been suggested for *significant* affirmative action: First, the use of rewards as the enforcing mechanism, rather than punishment; second, the conscious effort to hire and promote women who are identified with women, as demonstrated by their previous work history; and third, the effective guarantee that women hired into male-dominated workplaces will not be punished for voicing the concerns of the women they purport to represent.

My overwhelming sense of our group, throughout the conference, is that of wonderful *energy:* energy directed both toward working for change within established institutions, and toward the imaginative creation of alternative health services that are both competent and caring. This conference is one more benchmark in the process of development of the women's health movement. We will go forward, both as individuals in our own work and as a loosely affiliated group. I have heard talk about using the list of conference participants to keep in touch with each other; about establishing a women's health lobby so that we can work more effectively with the agencies and offices of the Federal Government; about issuing our policy statement, as the sense of this conference, to be brought by the U.S. delegation to the International Women's Year meeting in Mexico City; and about meeting again to share our energies, knowledge, skills, experience, and support of each other.

Our unity of purpose makes me believe that we *will* overcome. We women are three-quarters of all health workers; working together, we could transform our health care system. We are the consumers in nearly two-thirds of all visits to health professionals; working together, we could demand access to the knowledge and skills we need to provide good care for ourselves, our families, and our communities. And we are more than half of the population; working together, we could transform our society into a better place for women *and* men, young and old.

Closing Address

The Honorable Francoise Giroud

State Secretary for the Condition of Women
France

The situation of women in the health occupations is an immense and important issue, for it acts as a mirror, reflecting the state of a given society, showing what place women occupy in that sociey, also, what place women wish, consciously or not, to occupy in it, and what place they *could* occupy.

I shall not deal with the technical aspects of these occupations. Others here are far more qualified than I am for this. Nonetheless, I must give you some information about the French Public Health System, so that you may understand in what spirit I shall speak afterwards of the particular position of women in this system.

Practically all the French receive benefits under our health insurance, which we call "Assurance-Maladie". They make modest monthly contributions which are deducted from their salary, and to which employers add their share. This contribution is compulsory. Students, retailers, craftsmen, lawyers, physicians, etc. pay their contribution directly. Recently, this insurance has been extended to artists and writers. In 1978 there will not remain one Frenchman uninsured against sickness. All contributors receive reimbursement of their health expenses, 100% of the important expenses and 80% of the minor expenses. They, nevertheless, retain the right to choose their own doctor and also to be treated in a private rather than a public hospital if they so wish.

For all serious operations and diseases which require modern and sophisticated treatment, public hospitals are much better equipped than private facilities to provide the necessary care. Patients in public hospitals are treated by the best doctors.

It is in the public hospitals that, from the third year of the seven year medical studies, medical students obtain their clinical training while continuing to attend lectures at the university. After they have finished the studies, medical students must write their doctoral thesis and then they receive their medical diploma. As they are then Doctors of Medicine, they can then become practitioners and have their own private patients. If they wish to specialize, they must study three more years. If they wish to enter the hospital career, they must be selected by means of competitive examinations. In this context, the term "selected" means that in any case there are a limited number of candidates accepted and as they wish to go up the scale in their career, they must take more examinations. They may devote themselves entirely to hospital work and teach there as well, or divide their time between the hospital and their private practice. 171

Vis-a-vis the patients, I said earlier that they could choose their doctor, whether general practitioner or specialist. Doctors' fees are fixed by means of a Convention with the Government. Some doctors charge higher fees than others. Some private clinics charge more than the ones which have agreed—like doctors—on Convention-fixed prices. The non-Convention clinic patient pays the difference, unless he pays dues to a Mutual Health Insurance Fund, which is quite a common practice.

Why am I giving you these explanations? Because they mean that all employees of public and private hospitals are paid according to Government-fixed scales. This is also the case with infant-nurses and, more generally, with all women in health occupations.

All these employees, therefore, come under the control of the Minister of Health who also has responsibility for public day-nurseries and various social services. At the present time, this Minister, excellent in all respects, is precisely a woman who studied to be and is a magistrate. I shall, therefore, speak first of her situation.

It is interesting to me that when, for the first time, four women are members of the French Government, their responsibilities are limited to hospitals, children, prisoners and women—nothing, in short, that might frighten men and lead them to think that women may invade their territory. They remain in a sphere where their competence has never been questioned.

But then, what is health, or rather, what is illness, that women should be so attracted by the health occupations and that it should be so natural to accept them in these occupations? One could say that illness is, among other things, a state of weakness, of subjection, which likens the sick person to a child, and which, therefore, allows a sort of protecting power to exert itself over the sick. (When the patient is a man, the traditional psychological relationship between adult

man and woman is reversed, for, however young the woman nursing the patient, he identifies her as a mother figure.)

In France, there are as many women teachers as there are men. It is no accident that a considerable number of women are attracted to teaching as well as health for not only can women exert their power in this field, but this power is well accepted and perceived as a benevolent power, belonging to the natural order of things.

One finds, however, inside the health occupations, the same sharing of the roles between men and women, the same distribution as in ordinary life and production.

What then, can be noted if one examines this situation a little further?

Several paramedical professions are exclusively practiced by women, some by tradition, e.g., the matron of
172 olden times has become the modern midwife. Women have always had charge of the care of the children, the home, the sick. By becoming infant nurses, family helpers, nurses, or social workers, they only reproduce an eternal situation. That is, they only specialize, in one of their traditional functions.

This weight of the centuries and of tradition is felt even among doctors, as women are more likely to specialize in pediatrics or gynecology than in cardiology or gastroenterology, for example, although they are under no obligation to specialize in any given area.

One can not determine whether they do this because they feel a true calling or because they think it will enable them to reach a prominent position more easily. Both, I suppose.

There are other kinds of health occupations where, as in any other field of activity, women are the men's assistants. These include medical secretaries, ward-sisters, or anaesthetists. This division of roles in health occupations illustrates exactly the place society assigns to women, in both everyday and professional life as it results in the fact that the vast majority of women occupy the bottom levels of both the wage and power hierarchies.

As one goes up these scales in the medical profession, one finds fewer and fewer women. The reason is that, here as elsewhere, it does not yet seem quite natural for a woman to have authority over men, as she would were she the head of a hospital department.

During their studies, girls are treated exactly like boys. They take the same examinations, and, at the end of their studies, they obtain the same diploma, by which they may start practicing. If they stop at this point, and even if they specialize in order to devote themselves to a private practice, whether in town or in the country, they suffer no discrimination either in terms of prestige or income.

Most French doctors have joined the Government "Convention". This means that they have signed a contract with Social Security, which reimburses patients. Their fees are set by this contract, and vary according to the kind of medical service performed, e.g., examination at the patient's home as opposed to the physician's consulting room, and the physician's specialty, but the fees are, logically, the same for women and men doctors.

There are approximately 60,000 doctors practicing in France, including 14,000 women, and the number of women medical students is increasing. No specialist studies are closed to women. The image of female physicians among the people is good; they are trusted. There continue to be very few women surgeons. In this field, patients show more reluctance in accepting women. But this reluctance is slowly diminishing.

A few years ago, there was a T.V. serial about a woman doctor in the country which put the final touch to popularizing the image of the competent, long-suffering woman physician devoted to her patients.

If women wish to pursue a career in public hospitals, acquire diplomas, honors, become university professors and heads of hospital departments, things are quite different than in private practice. Of 60,000 medical doctors, 14,000 are women. But, of the 2,800 "professeurs agreges" at the top of the academic qualification, only 100 are women. While, by law, day nurseries must be headed by women, one wonders why—or rather one does not wonder why—it is so rare that a woman heads a hospital department.

It must be said that the French medical world is still dominated by a feudal system. That is to say, that a very narrow but very powerful class of men, called "les grands patrons" (the big bosses), who are mostly —no one denies it—great doctors, literally reigns over their departments, composes the juries for the examinations which must be passed to progress in hospital career, and possesses an exorbitant power over their students. These "bosses" are a caste which, like all other castes, tends to reproduce itself, and to transfer its power to its children. Thus, the majority of the "bosses" are themselves sons or nephews of "bosses." Perhaps in the future there will also be daughters of "bosses."

For the time being, however, the examination juries remain exclusively composed of men who, all other things being equal, automatically favor men in the race for diplomas, that is, for the top hospital functions. At the bottom of the scale, on the other hand, the health roles are largely left to women.

The consequences of the feminization of certain trades are well known: bad wages and poor social status. In France, the consequences of this situation are serious as we are particulary short of nurses. We have about 150,000 nurses in France, a number far below our needs. In the past, nurses were recruited essentially among either nuns or young country girls for whom the trade represented social promotion. Studies were short and simple. Today these studies have become much longer, and now last 28 months after the end of secondary education. The recruiting level is, therefore, much higher. Many young girls still become nurses by calling, out of liking for this work, but after an average of 5 years, they quit. Why?

In the public sector, which is the largest sector in

France, they consider themselves ill-paid. They are right. A beginner nurse earns about $400 per month. Then they discover that they have no real opportunity for promotion. Again, they are right. In order to pass the certificate of aptitude to become a ward-sister, they must have at least 3 years of experience in addition to their studies.

After a few years of experience, obviously, a nurse feels she knows as much or even more than a young doctor. The educational system, however, provides no bridge to allow her to acquire a medical diploma without having to become a student again for another seven years. Experience, what she has learned by practice, counts for nothing.

Lastly, when nurses marry and have young children, hospitals do not provide sufficient nurseries where they could leave their children while working. Besides, their working hours, which include night duty and Sunday work, are incompatible with family life.

All this is causing nurses to give up with increasing frequency and as nurses become fewer, harder is the work for those who remain. In some departments, there is only one nurse for 20 beds. The shortage is even greater of nursing-aides, who must undergo one year of training and do no nursing at all.

There is also a shortage of infant-nurses. The infant-nurse is a specialized nurse who has studies one year in addition to her regular nurses studies, and who assists the pediatrician in all public services where he (or she) works. There should be one infant-nurse per 100,000 inhabitants. We do not have one-third of this. They are also ill paid. This situation of general shortage has been vigorously denounced several times, and has even led to strikes. The Minister of Health is striving to change it.

We also need family helpers and social workers, as society uses growing numbers of them, and uses, in general, more medical and paramedical people, for obvious reasons, the first of which is the general rise of the level of knowledge in the population, and the popularization of medical information. The second and most powerful reason, no doubt, is that, as I have said, medical expenses are reimbursed.

Every person under Social Security in France can even have a yearly, complete, free of charge medical check-up. The total budget of what we call "Social Security" is greater than the whole budget of France. This is a clear indication of the scope of health expenditure in our country.

Thus, it is all the more shocking to have to say that a situation is to be found in the health occupations similar to the situation in all trades: the vast majority of women are kept away from the higher grades of the hierarchy, from higher wages, and from positions of decisionmaking power.

However, there is a subtle but not insignificant difference between women in other occupations. That difference is that women in health have a strong feeling, and it must be said, a rewarding feeling, that they are necessary, that they are useful. Useful, not to the promotion of goods, to a company's sales, or to a business leader's ambitions, but to both the whole of the human community and, at the same time, to each of the patients whom they nurse.

I personally do not believe that there is a specifically feminine nature, a particular biological disposition which causes women to dedicate themselves to service and men to dedicate themselves to commanding. There is no scientific proof of the existence of any such inborn inclination to self-sacrifice on the part of women. If this inclination is to be noted, however, although it is less and less, it is more likely attributable to culture, and to all that has weighed for centuries upon the unconscious mind of women, so easily persuaded that they are guilty, that they have to be forgiven for being women, and that they are not capable of doing what men can do.

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However, if I pursue these considerations, they shall lead me too far away from our subject. Whatever the causes, whether it is culture of feminine nature or even a roundabout way to recover a position of moral superiority, it is a fact that many women are in the various health occupations, that all paramedical professions are exclusively practiced by women.

Therefore, setting aside the material aspects of their profession, I invite you to consider one particular aspect of this situation. You know that, at all levels, occupations in the health field are strongly individualized. They have no mechanical character, and provide abundant human contacts.

A good example is the nurse. At the hospital, she has far closer relations with the patient than the doctor ever has. Illness for her is never theoretical. It is not something on which she lectures, or draws diagrams, or writes books. One could almost say she has the monopoly on the human relationship with the patient, just as women have the monopoly on the relationship with children since, from the mother to the day-nursery and then to primary school, children are reared almost exclusively by women.

Now, what do we do with this knowledge, thus accumulated by the nurse? What becomes of it?

In all disciplines, at every level, there is preoccupation nowadays with the problems of communication of information and transmission of knowledge, because we have learned that whomever holds knowledge holds power. The health professions seem to me very typical of a field displaying extensively the relation between information, knowledge and power.

I shall not surprise you if I say that medicine is no longer an art, but a science. There is apparently nothing in common between a 19th century hospital nurse and, for example, a nurse specialized in the use of the artificial kidney, who is a real technician without whom the apparatus cannot work. But the nurse remains the person who is in permanent contact with the patient, the person for whom disease is never an abstraction. She is, therefore, in a position to gather a considerable mass of information about the patient as well as about

the organization of the hospital department where she works.

What, in fact, becomes of this information?

Nothing much. In the first place, because a nurse, just as a doctor, in France, receives little or no training in this particular aspect of their jobs. The nurse is not taught to collect information which the patient may provide; she is not taught to listen to him. Even if she knew how to do it, she has so many tasks to accomplish that it is impossible for her to spend the time she judged necessary with a patient. Nor has she time to reflect methodically over the improvement of the conditions of hospital life, for listening and thinking are activities rarely considered work.

174 Nevertheless, although in an imperfect and incomplete way, she does gather information. Yet all the facts of which she is aware acquire the concrete value of knowledge only when the information is transmitted to the doctor. What does *he* do with it? He interprets this information according to his own knowledge, the medical knowledge.

The real power is then wielded by the doctor, since he sorts out information transmitted to him by the nurse. He rejects some, he retains other. Only the information he decides to retain builds up into Knowledge—with a capital "K." All the rest is lost. Unused. Neither the nurse nor the doctor use it.

But there is a great mass of knowledge of which the nurses, I repeat, have the monopoly. This can certainly be said of infant-nurses. This knowledge represents a considerable wealth.

I am saying this not only to remark that this wealth which women in health occupations possess is wasted, but to draw your attention to what could be done with it by these women.

To draw a parallel, let us for a moment consider the woman as an educator. Whether simply confined to her role as a mother, or whether she is a teacher, it is she who is in touch with the children. Particularly, the education received by children in the first years of their lives is entirely in the hands of women. To my knowledge, no scientific study has been made of the consequences of this phenomenon. The importance of these first years is well known, however, importance from the individual as well as from the social points of view.

It is not surprising that the most radical among the feminists do not exploit this monopoly over childhood which women retain. It has always been a wonder to me that they fight against men, that they strive to take their place, instead of rearing, as they have the means to do, different men and different women through the education they dispense.

And I note here also, that information on children gathered by women is rarely used. Here too, one does not know how to look and listen. Everybody speaks to children. Who really hears them? Who listens to them?

Sometimes, on the occasion of an illness or trouble of some kind, some information is communicated by the mother to institutions where they are sorted out, and the part which is retained is turned into knowledge. (Institutions—that is to say schools, or the medical world). Here also, on the one hand, information is largely wasted, lost, and on the other hand, knowledge and power are given up by the women to men.

It is true that we shall probably see in the future an increasing number of women entering positions which are apparently limited to men at the present time, and therefore, the distinction I made between those who gather information and those who transform it into knowledge-power, will no longer be such a cleavage between women and men.

It is true, progressively, we shall probably see the health occupations, at present exclusively feminine, practiced also by men, especially if salaries are raised. And this must happen, as the requirement for personnel grows. It is true that in couples where both husband and wife work outside, the education of children will probably grow to be shared more equitably between the parents.

This evolution will be slow. I think nobody has any illusions about this. But above all, it is an evolution which as yet concerns some women individually, rather than the mass of women.

For a long time yet, the unbalance will be to the advantage of men.

Because they are supposed to retain knowledge, they will in fact retain power, while much precious information on children and on the sick, on childhood and on illness—these spheres reserved for women—will remain unused while thousands and millions of women will remain at the bottom of society.

But I say that this society could be radically subverted by the women we are speaking about, if they decide collectively that they are worth more, because they know more, because they know something else. Because it is they who cover the immense field of human exchanges and relationships, the value of which are infinite.

But do they really want to transform society or do they simply want to take men's place, to act as men do, and to invert the roles, the dominated becoming dominant and vice versa?

This is an issue which goes beyond that of women in health occupations. Moreover, I do not know the answer to it, although I have a few ideas on it. It is not the subject you have asked me to treat. I hope that in the field in which you wanted me to speak, I have given you the information you expected.

Women as Producers of Services in the Health Sector of the United States *

Vincente Navarro, M.D., D.M.S., Dr. P.H.
Associate Professor
Department of Medical Care and Hospitals
and Department of International Health
The Johns Hopkins University
Baltimore, Maryland

In the same degree that we in the United States "discovered", or "rediscovered", the blacks and the poor in the 1960's, we seem to be discovering the women in the 1970's. And that discovery appears in all economic and social sectors, including the health one. Many studies and articles have appeared translating that discovery. Still, most of the lengthy bibliography that has appeared on the subject (to document and analyze the extent of sexism in the health sector) seems to focus on the problems faced by the professional woman. But, however, important those problems may be, they are only a part—a small part at that—of the far larger problems encountered by all women who are producers of services in the health sector. The objectives of this article are (1) to describe the situation of not only a few but all women who are producers of services in the health labor force within the context of the overall labor force in the United States; (2) to give my own interpretation of some of the factors that cause that situation; and (3) to describe a possible strategy for change.

In trying to understand the situation of women as produces of services in the health sector, we have first of all to focus our analysis (1) not on the world of women but on the world of men, and (2) not just on the health sector, but primarily on the socioeconomic forces of the entire society that determine the function, nature, and composition of that sector to start with. Indeed, I believe that most sociological research done on this subject has had two major weaknesses which I postulate has led those studies to conclusions that have been empirically invalid and ineffective policy-wise.

The first weakness of that research is that most of the analyses on the current situation of women have tended to focus on women as if they themselves were responsible for that situation. I disagree with those analyses, since I believe that the so-called "women's question" or "women's problem" is actually the problem of men and society, i.e., to understand the present situation of women as producers in the health sector, we must understand the distribution of political and economic power in the world of men. Actually, we can see that what is happening in the analysis of what is usually referred to as the women's question in the 1970's is very similar to the studies and analyses of poverty and the poor that were made in the 1960's. When poverty was "discovered" in the U.S. in the 1960's, many studies were conducted on the poor and on the culture of poverty. Very few studies, however, examined the economic and political system which determined that poverty. As a result of this singular focus, the strategies for improving the conditions of the poor were named in terms of the poor themselves. Today, we have as many poor people—if not more—as when those strategies started.

In the 1970's one can see a replication of this singular focus in the study of the so-called women's question, in which most of the focus is on women, and very little is on the social and economic systems, controlled by men of defined class backgrounds, which determine the inferior social and economic status of working women. Just as poverty cannot be understood without an understanding of wealth, the distribution of wealth, and the reasons for the wealth and income differentials in this country, the situation of women in the health sector cannot be understood without an understanding of the world of men and the distribution of the social, economic, and political power within that world. To understand the situation of women, then, one must analyze not women as such, but the entire socioeconomic and political system that generates, creates, and perpetuates the present situation of women.

The second erroneous focus of a large number of those sociological studies on women as producers in the health sector has been to focus on the health sector itself, i.e., an analysis of the social forces within the health sector as determinants of the distribution of responsibilities within that sector. In doing so, however, the assumption was made that the health sector was autonomous and had a dynamic of its own. An example of this erroneous focus is the "great sales job" that is currently being done by quite a number of

* Not delivered at Conference, but published by invitation in Conference Proceedings. In the biographical information distributed during the Conference, Dr. Navarro should have been identified as a consultant to the U.S. Agency for International Development rather than as a consultant to the World Health Organization.

international agencies—including the World Health Organization—trying to export the very interesting and I would add positive experience of the Chinese barefoot doctors to other developing and even developed countries. In this promotional activity, an interesting and positive element of the Chinese health services is assumed to be exportable to other countries as well. And yet, as the fascinating and candid account of a group of Iranian health workers who unsuccessfully tried to import and implant that Chinese experience to Iran indicates, that experience is not transferable to other countries possessing different economic and political systems.[1] Indeed, those exporters seem to be unaware that the very creative and imaginative use of personnel, implied in the barefoot doctors' experiences in the People's Republic of China, assumes
176 and subsumes a series of political, economic and social values that are more the exception than the rule in the countries where those experiences want to be exported.

Similarly, in this country, the increased intention to replicate the successful Chinese and Cuban movements of self-reliance and self-care reflects a lack of awareness that those movements in those countries do not have an explanation and autonomy of their own, but rather, they are part and parcel of broader political and social forces that determine and explain the composition, nature and functions of those movements, broader political and social forces, I may add, that are, for the most part, absent in our society.

Let me clarify here that none of my comments should be understood as a note of skepticism about the learning value of international studies, or international conferences for that matter. Rather, they are made with the intention of stimulating a broadening of those studies and conferences to include the analysis of the tree—the present situation of women as producers in the health sector—within the comprehension of the forest—the distribution of social, economic and political power in those societies. This is the intention of my presentation.

Sex, Class and Occupational Structure of the U.S. Labor Force

Let us begin, then, with analyses of the distribution of social, economic, and political power in our society, starting with an analysis of the class, sex, and occupational structure of our population and our labor force. At the top of our society there is a relatively small number of people, the majority of whom are male who own a markedly disproportionate share of personal wealth and whose income is derived largely from this ownership. Many of these owners also control the uses to which their assets are put. However, increasingly, this control is vested in the managers of that wealth who, although wealthy themselves, do not personally own more than a small part of the assets which they control. Both the owners and controllers of wealth constitute the upper class or, for reasons to be later defined, *the corporate class*. By virtue of ownership or control, or both, they command the most important sectors of economic life. Actually, the skewness of that ownership and/or control is revealed by the following facts: according to Hunt and Sherman, the most complete study on the distribution of ownership of wealth ever undertaken in the United States showed that in 1956, 1.6 percent of the population owned at least 80 percent of all corporate stocks (the most important type of income-producing wealth) and virtually all state and local government bonds.[2] Although no subsequent studies have been done on the individual ownership of wealth, it seems highly unlikely that this concentration of economic wealth has changed significantly between 1956 and the present time.[3] A similar concentration appears in the distribution of income. Actually, Samuelson, in an excellent and graphic analogy in the eighth edition of his *Economics* states that:

> if we made today an income pyramid out of a child's blocks, with each layer portraying $1,000 of income, the peak would be far higher than the Eiffel Tower, but almost all of us would be within a yard of the ground.[4]

At the other end of the social scale there is the *working class*, composed primarily of industrial or blue collar workers (20 percent women); workers in the service sectors (83 percent women); and agricultural wage earners (3.3 percent women), although the latter constitutes a steadily decreasing segment of the labor force.[5] In 1970, these groups represented 35 percent, 12 percent, and 1.8 percent of the labor force, respectively.[6] This working class remains everywhere a distinct and specific social formation "by virtue of a combination of characteristics which affects its members in comparison with the members of other classes."[7] It is also primarily from their ranks that the unemployed, poor, and the subproletariat come.

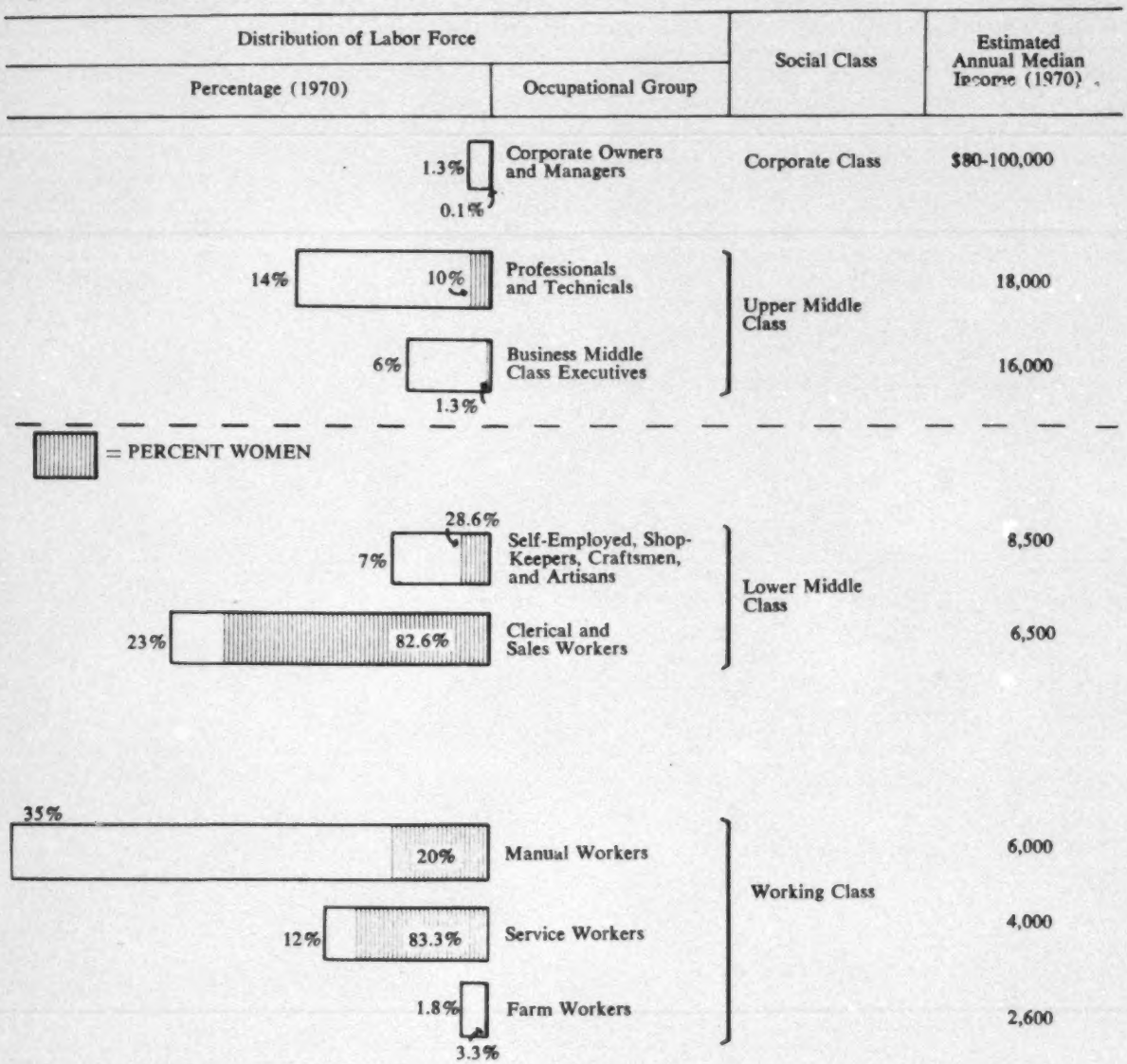
Between these polar classes, there is the *middle class* which consists of: (1) professionals (10 percent women)—including doctors, lawyers, middle-rank executives, academicians, etc., whose work is intellectual as opposed to manual, and usually requires professional training; (2) middle-class businessmen (1.3 percent women)—associated with small and medium-sized enterprises, ranging from those employing a few workers to owners of more sizeable enterprises of every kind—these are the owners and controllers of O'Connor's competitive sector[8] or of Galbraith's market sector[9] of our economy; (3) self-employed shopkeepers, craftsmen, and artisans (28 percent women)—a declining sector, representing less than 8 percent of the labor force; and (4) office and sales workers (the majority of the white collar workers and 82.6 percent women)—the group within the labor force that has increased most rapidly in the last two decades and today represents almost one-quarter of the labor force of the United States and of most Western European countries.[10]

For reasons of brevity, and accepting the simplifications that this categorization implies, I shall refer to

groups 1 and 2 as the upper-middle-class, and groups 3 and 4 as the lower-middle-class. It is worth underlining that the lower-middle-class is closely related to the working class in terms of income, status, and life style. For example, most women clerical and sales workers are married, and about one-half are married to working class men. Figure 1 summarizes the percentage of the labor force in each occupational group (and the sex composition within each group) and each social class and gives the annual median income for the occupational groups.

The distribution of wealth and income follows these class lines, with the highest possession of both found at the top and the lowest at the bottom. Moreover, these distribution patterns of wealth and income have remained remarkably constant over time. In the most recent retrospective study of the distribution of income published in the 1974 annual *Economic Report of the President* [11] which was widely reported in the press, it was found [12] that the bottom 20 percent of all families possessed 5.1 percent of the nation's income in 1947 and had almost the same amount, 5.4 percent

Figure 1: Occupational, Social Class, and Sex Distribution in the United States



Source: Navarro, V., Social Policy Issues: An Explanation of the Composition, Nature and Functions of the Present Health Sector of the United States. Paper presented at the Annual Conference of The New York Academy of Medicine, April 25-26, 1974.

in 1972. At the top, there was a similar absence of significant change. The richest 20 percent of the population possessed 43.3 percent of the nation's income in 1947 and 41.4 percent in 1972.

Sex, Class, and Occupational Structure of the U.S. Health Labor Force

This class, sex and occupational structure of our society is also reflected in the composition of those who participate in the health sector, either as owners, controllers, or producers of services. Indeed, considering only the health sector, and analyzing the owners, controllers, and producers of services in health institutions, we find that all members of the upper class and, to a lesser degree, the upper-middle-class (groups 1 and 2 of the middle class), predominate in the de-
178 cisionmaking bodies of our health institutions, i.e., the boards of trustees of foundations, teaching hospitals, medical schools, and hospitals. Moreover, in analyzing the class composition of the health labor force in 1970, at the top we find the physicians, who are mainly of upper-middle-class backgrounds and who had an annual median net income of $40,000, which places them in the top 5 percent of our society. Besides being upper-middle-class, the majority of persons in this group are white and male. They represent 7.3 percent of the total labor force in the health sector.

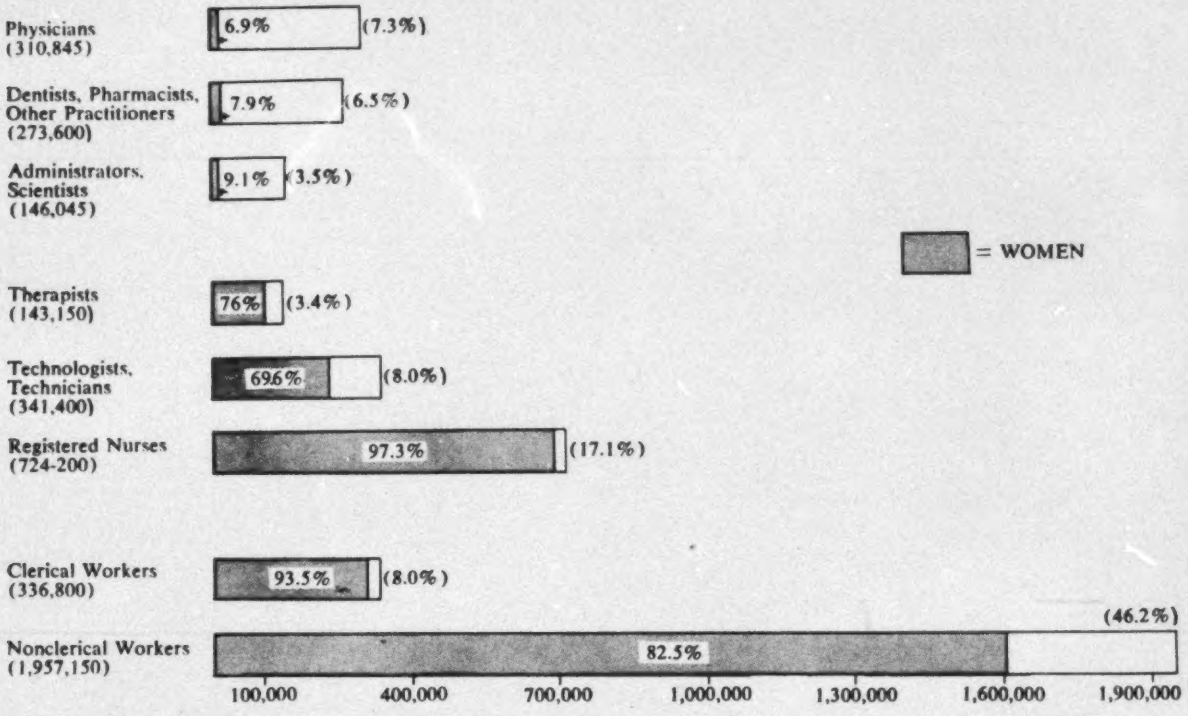
Below, far below, the members of the upper class of the health sector, we find the paraprofessionals. This group is equivalent to the lower-middle-class, office-worker group, i.e., nurses, physical therapists, occupational therapists, etc., whose annual median income was approximately $6,000 in 1970. They represented 28.5 percent of the labor force in the health sector. This group is primarily female and is part of the lower income group. Nine percent of the group is black.

Below this group we find the working class per se of the health sector—the auxiliary, ancillary, and service personnel—representing 54.2 percent of the labor force, predominantly composed of women (84.1 percent) and including an over-representation of blacks (30 percent). This group's annual median income was $4,000 in 1970. Figure 2 summarizes the sex, occupational and social class structure of the health labor force.

If we look at wage differentials in the health sector as we did for society in general, we find a similar structure, although here again we find a great scarcity of information and a great absence of empirical data.

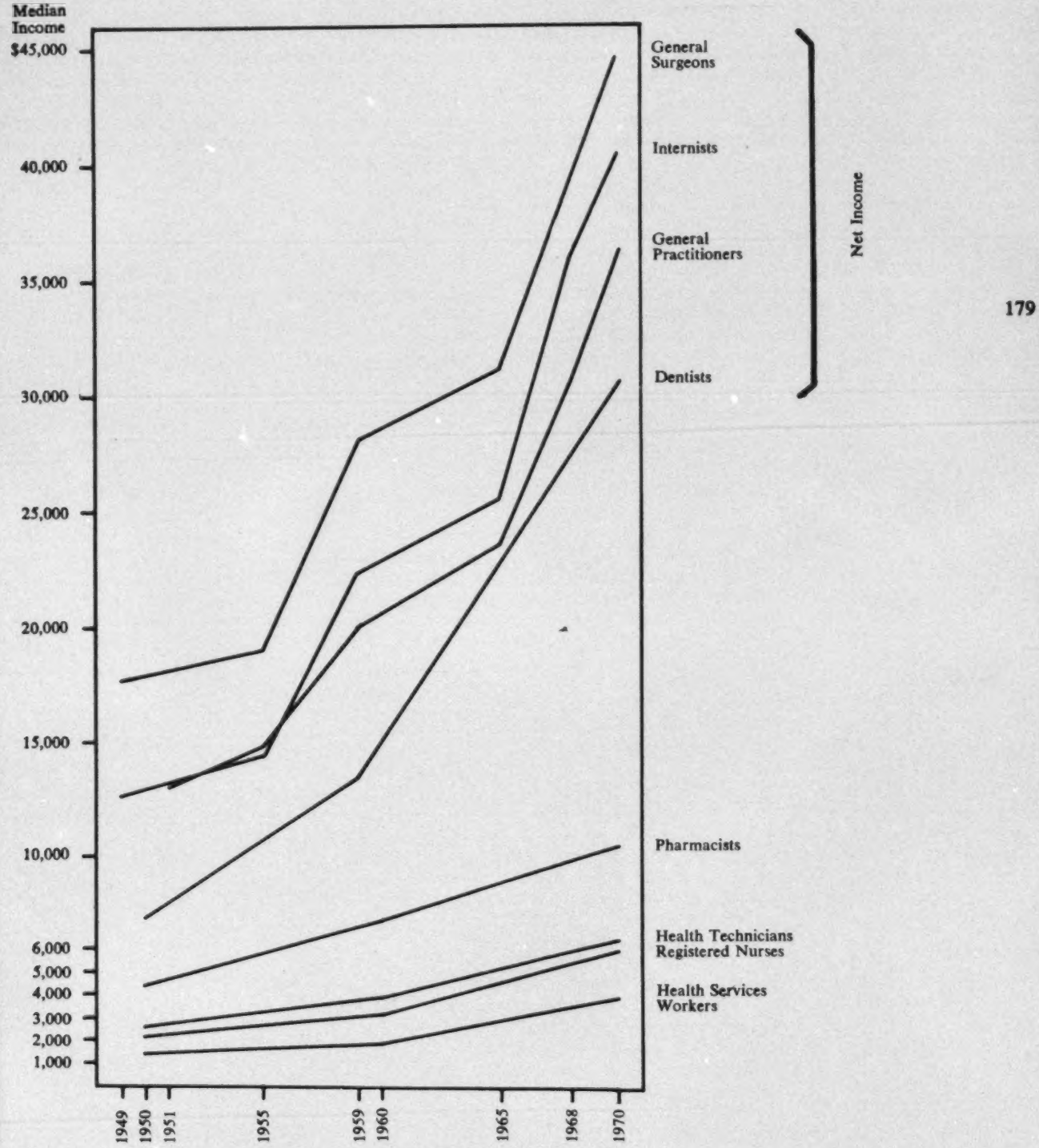
Figure 3, however, shows the trend in the differentials of annual median income among the different groups of producers in the United States health sector from 1949 to 1970. We can see that there has been a very large increase in the income differentials between the top and bottom income groups of the health industry.

Figure 2: Persons Employed in the Delivery of Health Services in the United States, by Sex, in 1970



Source: Navarro, V., Social Policy Issues: An Explanation of the Composition, Nature and Functions of the Present Health Sector of the United States. Paper presented at the Annual Conference of The New York Academy of Medicine, April 25-26, 1974.

Figure 3: The Rise in Income of Selected Personnel in the Delivery of Health Services in the U.S. 1949-1970



Source: Navarro, V., Social Policy Issues: An Explanation of the Composition, Nature and Functions of the Present Health Sector of the United States. Paper presented at the Annual Conference of The New York Academy of Medicine, April 25-26, 1974.

An Explanatory Set of Variables for the Sex, Class and Occupational Structure of the U.S. Labor Force: The Economic Structure of the U.S.

Why do the income differentials follow sex as well as class lines? Here again, we have to go outside the health sector and analyze the sex and class structure of the labor force in the three main sectors of the economy: (1) the planned or monopolistic sector; (2) the market or competitive sector; and (3) the state sector.

The first, the planned or *monopolistic sector,* employs roughly one-third of the labor force. It is capital intensive as opposed to labor intensive, national in contrast to regional or local, and highly monopolistic both in economic concentration and in economic behavior (e.g., in the use of price-fixing). The important
180 characteristics of this sector are its requirements for economic stability and planning and a tendency toward vertical integration (e.g., the control of raw materials from the point of extraction to the process of production and distribution) as well as horizontal integration (i.e., the control of different vertical sectors of the industry and the establishment of conglomerates). If we look at the social makeup of this sector, we find: (1) the corporation owners (or stockholders) and the controllers (or managers), predominantly male—who, Galbraith says, together make up the "corporate community",[13] which Miliband labels the "large business community" [14]—who, according to my own definition as outlined above, would be called the corporate class; (2) the technocracy or professionals, predominantly male (group 1 of my categorization of the middle class); (3) the blue collar workers, predominantly male, who are highly unionized and who correspond to the industrial working class of my previous categorization; and (4) the white collar workers, the technical and administrative workers or lower-middle-class, predominantly female.

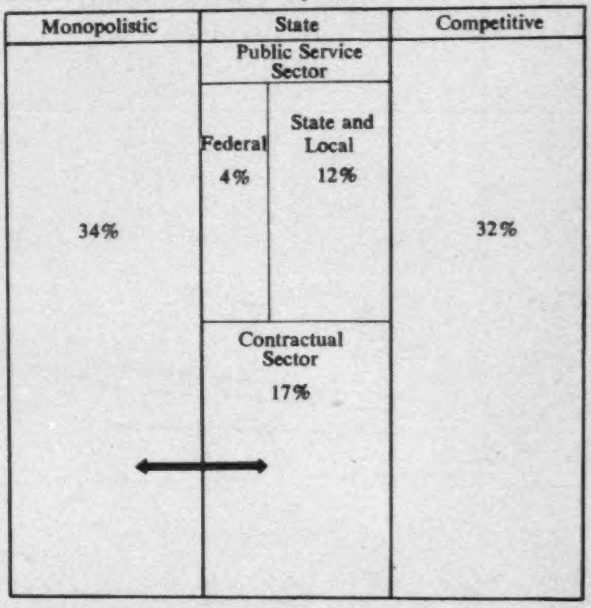
The second sector of the economy, the market or *competitive sector,* was once the largest of the three sectors, but today is the smallest and continues to decline. It employs roughly less than one-third of our labor force, with the largest proportion of workers being in services and distribution.[15] The competitive sector is characterized by being labor intensive and local or regional in scope, with a relatively weak labor force and low unionization. Examples of workers in this sector are people working in restaurants, drug stores, commercial display, etc. The social makeup of this sector consists of: (1) the owners and controllers (executives) of small-scale, localized industries and services (group 2 of my categorization of the upper-middle-class); (2) a small percentage of blue collar workers; (3) a small percentage of white collar workers; and (4) a large percentage of service workers, primarily auxiliary and ancillary personnel. Groups 3 and 4 are predominantly female.

The third major sector of the economy is the *state sector,* which consists of two subsectors. The first subsector produces goods and services under the direction of the state itself, e.g., public health services; the second subsector involves production organized by industries under contract from the state. The contracts (e.g., for military equipment and supplies) are mainly with corporations belonging to the monopolistic sector. In terms of social makeup, the first subsector, employing approximately 17 percent of the labor force, has characteristics similar to those of the market system, while the other subsector—the contractual one—also employs 17 percent of the labor force and is part of the monopolistic sector. Figure 4 summarizes the percentage of the labor force in each sector, and Figure 5 summarizes the main characteristics of the production and labor force in each sector.

The health labor force has the characteristics of the competitive sector, i.e., it is predominantly female, poorly paid, and poorly organized and unionized. Indeed, as shown in Figure 2, we can see how the occupational and sex composition of the health labor force parallels that of the labor force in the competitive sector.

Actually both the competitive sector and the health services are supportive sectors and services to the main sector of the U.S. economic structure, i.e., the monopolistic sector. Indeed, this monopolistic sector (including large financial and corporate capital) is the sector that has the dominant influence in the national economic and political institutions of our country, and, as I have indicated elsewhere, in the health institutions as well.[16] And the nature and composition of the supportive services are much determined by the needs of that sector. The consequences of that

Figure 4: Approximate Percentage of Labor Force in Each Sector of U.S. Economy



Source: J. O Connor, *The Fiscal Crisis of the State,* St. Martin's Press, 1973; V. Bownell and M. Reich, *Workers and the American Economy: Data on the Labor Force,* New England Free Press, 1973.

Figure 5: Production and Labor Force Characteristics of Each Sector of the U.S. Economy

	MONOPOLISTLC	STATE		COMPETITIVE
		Contractual	Service	
	• Primarily manufacturing	• Primarily service		• Primarily trade and service
CHARACTERISTICS OF PRODUCTION	• Economic concentration	• Economic deconcentration		• Economic deconcentration
	• Highly monopolistic	• Monopolistic		• Competitive
	• Vertical and horizontal integration (conglomerates)	• Vertical and sectorial		• Vertical and sectorial
	• National and International	• Federal, State, Local		• Regional and local
CHARACTERISTICS OF LABOR FORCE	• Predominantly male	• Predominantly female		• Predominantly female
	• Nonwhites: underrepresented	• Nonwhites: proportionally represented		• Nonwhites: overrepresented
	• Unionized	• Nonunionized		• Nonunionized
	• Salaries: relatively high	• Salaries: medium		• Salaries: low

Source: Navarro, V., Social Policy Issue: An Explanation of the Composition, Nature and Functions of the Present Health Sector of the United States. Paper presented at the Annual Conference of The New York Academy of Medicine, April 25-26, 1974.

relationship in which the health services are both supportive and dependent are many. But not a minor one, as explained in the next section, is the feminization of the labor force of the supportive sectors—such as the competitive sector—and of the supportive services—such as the health services.

The Whys of Sex Discrimination in the Health Sector

Among the socioeconomic factors that explain the situation of women, I would single out the social and economic role of the family in society as being a main determinant of the division of labor in the economy, including the division of labor within the health sector. Indeed, in the distribution of responsibilities within the family, the main function of the husband is to be an active member of the labor force and the agent of production. The wife is responsible for maintaining (taking care) and reproducing the family. Within this distribution of responsibility, the employer pays for the work of one person, but actually gets the work of two. If employers paid for the housewife's work, there would be considerable economic costs that are now completely avoided, and the savings of which to the employer are not even taken into account. Instead, the only compensation for this work is what is usually referred to as the "emotional rewards" that the wife derives from working and caring for her family. This "emotional rewards philosophy," with the concomitant division of labor within the family, however, benefits primarily the employers in society, again, who pay for the work of one, and get the work of two.

Another socioeconomic factor that explains the division of labor within the family is the economic usefulness for the economic system of having a reserve army of workers, i.e., the women who work at home whose value of the economy as workers outside the home depends on the need for labor within the economy. Therefore, it is during periods of labor shortages that women are encouraged to move into the labor force, but when there is large unemployment, as there is now, the political and economic structure does not encourage, but rather hinders the entry and involvement of women in the labor force. No doubt, the lack of receptivity of both the Nixon and Ford Administrations toward the creation of day-care centers in this country can be explained, to a large degree, by the fear of further increasing the unemployment situation in the United States.

These two socioeconomic factors, among others, explain the social and economic usefulness of the present division of labor within the family, with the "woman's work being primarily at home". Moreover, this very division of labor and the values that support it are continually reinforced and perpetuated by all the systems of communication and education in this country that sustain the conventional social virtues—the virtues that, as Galbraith [17] writes, are the ones supported by the powerful in society. One of those virtues is the merit ascribed to the woman who is a good homemaker. To do something else would be "neglectng her home and family, i.e., her real work. She ceases to be a woman of acknowledged virtue".

This role division within the family also appears in the health sector, with the predominantly upper-class, white, male physicians being, according to the conventional wisdom, the unquestioned leaders of the health team, the nurses and paraprofessionals, predominantly female, the dependents and appendages to the physicians, and the auxiliary and ancillary personnel, predominantly female, and working class by definition. Actually, this set of relations was seen in just this way by none other than Florence Nightingale, who perceived the characteristics of the nurse as providing wifely support to the physician, motherly devotion to the patient, and firm but kind discipline to the attendants and auxiliaries.[18] And an example of how the media reinforces these role definitions and the values that support them is the most popular television program in the United States dealing with health care, "Marcus Welby," which has been idenified by Congresswoman Shirley Chisholm as the "great lie in TV on medical care," i.e., all MD's who are men and upper class, are thoughtful and compassionate, with

the nurses being presented as nice, sweet females who are appendages to the physician.[19]

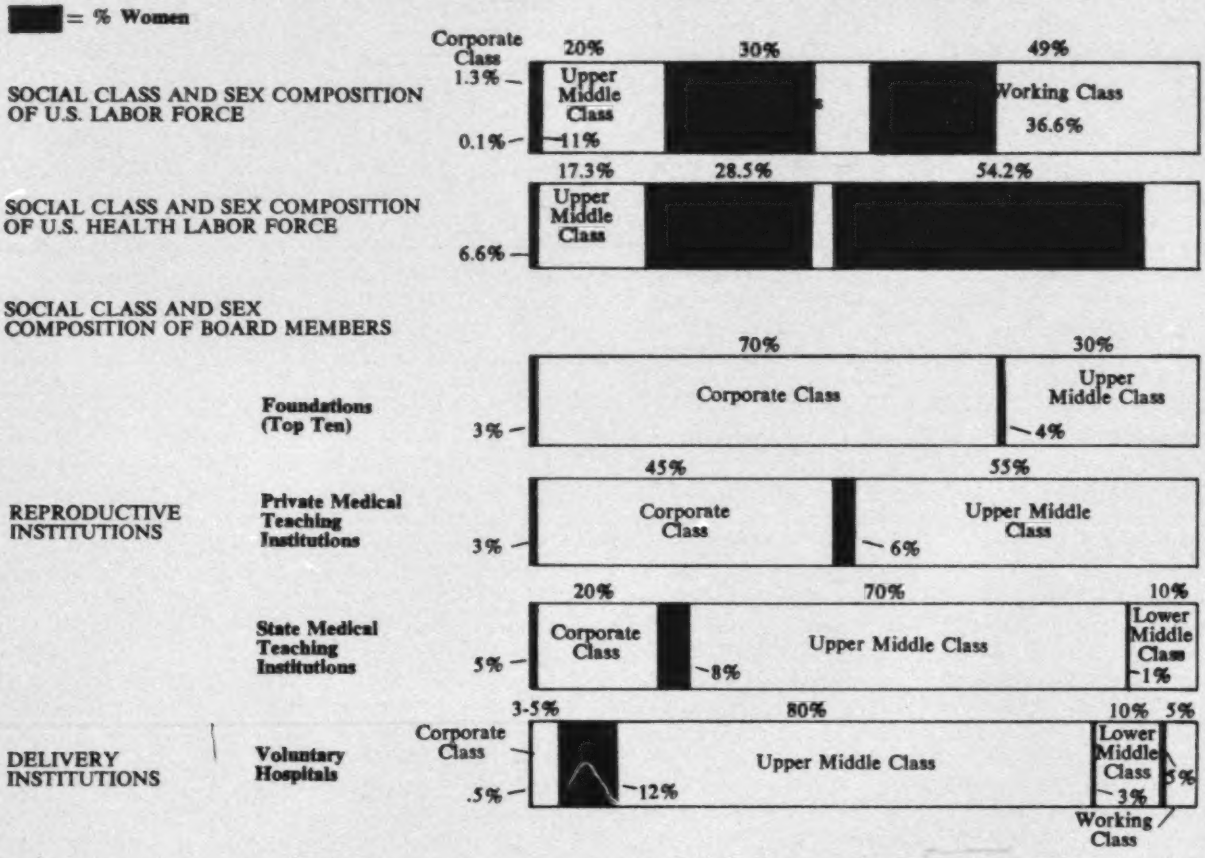
Given these social and economic needs of the system, it is quite logical that women tend to be the majority of workers in a sector whose main function within the economy is to provide care to and maintenance of the population, and that, within that sector, women tend to perform the conditional and dependent jobs.

This situation, briefly described above, is found not only in the social and economic spheres of society, but also in the political ones, owing to the patterns of control and dominance over the decisionmaking process of institutions both outside and within the health sector.

This fact can be seen by reviewing the sex and class composition of the boards of trustees of institutions
182 in the health sector. Actually, within the health institutions there are the reproductive institutions, such as the foundations and medical teaching institutions, that serve to reproduce the human resources in the health sector, and the delivery institutions, e.g., the acute hospitals that provide the services. Of the delivery institutions, the acute hospital sector is the most important one in terms of consumption of resources. For both types of institutions, Figure 6 shows the class and sex composition of the labor force within and outside the health sector in the United States, of the boards of trustees of the top ten foundations in the medical sector in this country, of a representative sample of private and state medical schools, and of acute hospitals.

One can see in Figure 6 the very low representation of both women and the lower-middle and working classes—the majority of the United States population —in the decisionmaking bodies of health institutions. The majority of producers, both in the health sector and in the rest of society (who in the health sector are women), are practically nonexistent in the corridors of power in the health sector. A similar situation appears in the different agencies of government in the health sector, in which corporate leaders and the professional and business upper-middle-class, most of them males, predominate in the Federal, State, and local branches of government.

Figure 6: Estimated Social Class and Sex Composition of U. S. Labor Force, Health Labor Force, and Boards of Trustees of Reproductive and Delivery Institutions in the Health Sector



Source: Navarro, V., Social Policy Issues: An Explanation of the Composition, Nature and Functions of the Present Health Sector of the United States. Paper presented at the Annual Conference of The New York Academy of Medicine, April 25-26, 1974.

A Possible Strategy for Change

From this analysis of the sex and class structure of the labor force both outside and within the health sector, it should be clear that it is highly unlikely that profound and meaningful changes will take place for the benefit of the majority, and not just a minority, of women—and men—unless the patterns of influences and controls of the economic, political, and social (including health) institutions change, with a change in the sex and class composition of the systems of governance of our society, to make these patterns of governance representative and accountable not to a minority but to the majority of our population. And this applies to the health sector as well as to any other sector.

Indeed, if women's liberation means the struggle for the liberation of not just a few but of all women, then that liberation movement cannot limit itself to the battle for the advancement of upper and upper-middle-class women, but, rather, must link its struggle with a larger struggle for the democratization of our institutions that would give the majority of women—and men—in our population, the working class and lower-middle-class population, a control over the institutions they support, work, and pay for.

Allow me to emphasize this point which I believe to be a critical one, in order to define whether women's liberation is indeed part of the solution or rather part of the problem. Indeed, to limit the concern of women's liberation, as large sectors of that movement do, to the fight for the advancement of those who belong to the upper class and upper-middle-class, leads to merely a change of the sex composition of those at the top, leaving those at the bottom, both women and men, unchanged. Actually, I postulate that this is precisely what is taking place today. Let me illustrate this with just two examples. One is that the increased inclusion of the city mothers to the boards of trustees of our institutions, controlled so far by the city fathers, is leaving the situation of the majority of our citizens, the city orphans, completely unchanged. Another example is that while the number of women among medical students has been increasing very substantially in the last five years, the percentage of women—and men—coming from the working class and lower-middle-class families has remained unchanged and constant in the last sixty years![20] Class discrimination is indeed the most persistent, continuous, and least discussed of all discriminations.

In summary, if our concern is for the fate and life of the majority of women—and men—in our society, then our strategy should be one of making women's liberation part and parcel of an authentic human being's liberation, where our society will be designed to benefit the many, and not just the few. And the betterment of the many will be related to the degree that the many are represented in the sources and corridors of power, presently controlled by the few. It is because of this that the demand for the rights of women in the health sector is intrinsically related to the demand for a more democratic, representative, and accountable system than we have today. As Mother Jones, that great trade union leader among the Appalachian miners said, "It is to break with the control that the few have over our lives, that we need the work and the struggle of all of us". It is in terms of this understanding that the struggle for women's liberation also implies the struggle for the liberation of us all.

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Post-Conference Remarks by Steering Committee Members

George A. Silver, M.D.
Professor of Public Health
School of Medicine
Yale University
New Haven, Connecticut

It was gratifying to see the interest and commitment of the participants from the various U.S. groups and the intensiy of response. It demonstrated vividly how important and necessary this conference was. Further, the fact that this was the first such national forum for expression was bound to release much more exaggerated sentiments, since these emotions had been bottled up for so long with no appropriate vent. It underlines the need for many more such opportunities to be made available, properly structured to permit the energies to be channeled into useful directions for effective change.

The enormous hostility expressed toward doctors, and not just as representatives of the dominant profession, did make me uncomfortable. I have the feeling that the doctor should be usefully placed into any future medical care system, though perhaps not in as powerful or dominating position as he now has. I would hope that the profession would not be done away with altogether!

The discussions of mixed political and professional criticisms and suggestions reminded me strongly of the plea made 20 years ago by Sir Theodore Fox for a "Greater Medical Profession", inclusive rather than exclusive.

Many important issues were presented here for the first time: the unpaid medical role so many family members (usually women) are required to play by inadequately structured medical care delivery systems, for example. But some issues, although reasonably well-known, still cannot be repeated and emphasized enough. I have reference here to the class and sex nature of task assignment and pay in the medical field for one; and the lack of women in decisionmaking roles in the medical field. It was remarkable that there was such unanimity in this response from so many different countries. With the exception of China (and there was no Chinese representative present, but someone spoke for China) no woman from any country was satisfied that she received equal treatment or had equal opportunity for advancement in her profession. It is true that the women from the socialist countries defended their political system and pointed out how much the status of women had advanced under their political system, but in no case could it be said that true equality existed.

The most disappointing aspect of the conference, to my mind, was the way it was ignored by the media and the established power structure. While representation from HRA was staunchly loyal and appeared and participated, no one from the Executive Branch attended for the purpose of *listening*. Secretary Weinberger came and talked and went off; Mr. Veneman did the same. There was practically no newspaper coverage, no radio or TV coverage. Since a number of women are influential in those fields: Mrs. Graham publishes the Washington Post; Barbara Walters *is* the TODAY show.

But to me, the conference was a success because it allowed ordinarily unheard voices to be heard; because women from many parts of the world spoke of common problems and shared common concerns; because it is important, on as many occasions as possible, to "speak truth to power."

Jeanne Spurlock, M.D.
Deputy Medical Director
American Psychiatric Association
Washington, D.C.

I am sure that I share the feelings of the majority, if not all, assembled of being favorably impressed with the proceedings.

Considerable emphasis has been placed on the need for improvements in the health care systems so that health care can indeed be a right for everyone. We have learned of a number of programs that have, and should, make this right a reality.

There have been repeated references to the observation that it's still a man's world in most countries. Yet, we have heard of the progress of women in the initiation, as well as the accomplishments, of many reforms

pertaining to health care. The speakers have presented illustrations of the accomplishments and achievements of women paralleling, and often surpassing, the contributions of men in the health field. However, little attention has been given to the ripple effect of the proposed, as well as the accomplished changes, and how we can best handle the untoward effects. There is no question that there will be ripple effects; we've seen them already. A painful illustration: the recent changes of HEW in regard to the nullification of hearings pertaining to individual complaints of discrimination. Subtle, and not so subtle, efforts have been directed toward decreasing the number of women in medicine. It has been reported [1] that one medical school dean spoke of letters, threatening to curtail donations, from male alumni who felt too many
186 women had been admitted.

There have been only a few references to the influencing factors of classism and racism, both of which I strongly feel have played an integral part in the brain drain phenomenon, a practice which all of us so deeply deplore. We, who have participated in the planning of this conference can perhaps justifiably be accused of being somewhat guilty of these practices. Yesterday, it was mentioned that we had no representation from Cuba, our very close international neighbor. But, we needn't look that far to observe absent representation. We have had no representation from Native Americans, and have had only minimal representation from the colored peoples of the world, even though the majority of the world population is nonwhite. It is essential that we carefully look at the problems related to classism. Of particular importance in this country is the rising cost of medical school tuition; costs which will make medical school attendance next to impossible for individuals who aren't from economically well-off families.

Another issue we have not attended to is the fact that women are not a homogeneous group. There are scores of women in this country, and I would charge in every country, who would prefer to see and consult with male health professionals at policymaking levels. Many women demean the services provided by a nurse's aide or a paraprofessional. However, we cannot disregard these women any more than we can disregard the fact that women, too, are not free of biases that have thwarted the efforts to make health care a right for everyone.

It has been impressive to hear the emphasis given, by a number of participants, to the need for support systems. There is no question that health professionals, alone, cannot provide good health care services for the total population. It's essential to be alert to this fact as we go about planning for prevention, as Congresswoman Keys has mentioned. Others, too, have stressed this point. Problems of poor housing, overcrowding, hunger, and poor nutrition must be alleviated if people are to enjoy good health.

Hopefully, when we return to our respective communities, we'll continue to work toward the goals identified at this conference.

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Recommendations of the Steering Committee for the International Conference On Women In Health

June 16-18, 1975

Data Collection and International Research

1. More complete and current data on the status of women in selected health occupations, both in the U.S. and in other countries, are essential to the research and program development necessary to improve the status of women in the health field. Therefore, *it is recommended that data on the status of women as applicants, students, providers, and consumers in the health field in the United States be compiled and published biannually by the National Center for Health Statistics.* Other government agencies and health professional associations which collect data related to health personnel should be encouraged and engaged to compile and publish data by sex for the United States. The World Health Organization (WHO) and the Pan American Health Organization (PAHO) should also be encouraged to publish comparable data from other countries.

It is further recommended that a final edition of the chartbook entitled "Women in Health Careers," which was developed and used as a working document for the conference, be published in the near future.

2. The conference reinforced the viewpoint that we have much to learn from other countries that would be useful in improving the utilization of women in the health sector. In addition, the meeting permitted the identification of several specific areas for international collaborative study which have potential value to the United States.

It is recommended that the flexible training programs and support services available for both male and female health care workers in Scandinavian countries be studied for their potential relevance to the Untied States. The study should evaluate the impact of such programs and services on the utilization and career choices of women and the impact of such policies for the health care system. In addition, the Swedish parenthood benefit model, an innovative benefit system for caring for newborn children by either parent, should be studied in terms of its possible utility in the U.S.

It is further recommended that a study on the status of women in all health professions in Poland and their role as decisionmakers relative to men in the health sector be developed under the U.S.-Polish Special Foreign Currency Program (P.L. 480). This study would include an analysis of the factors related to the relatively low participation of women in decisionmaking positions compared to the relatively high proportion of women in the health professions. The study should also include analysis of data on marital and family status, working hours and career span of female health care workers in comparison with their male counterparts.

Program Recommendations

1. Regional Conferences:
   The chartbook on the status of women in health careers, the photographic exhibit illustrating women working in forty-two different health occupations, and the videotapes of the Conference are immediate outcomes of the meeting and are valuable re-
   HRA. In order to further disseminate the outcomes of the Conference, *it is recommended that* sources to be used for program development in *these materials be provided to the DHEW Regional Offices for the purpose of developing one-day conferences regarding women as health care providers.* Edited segments of the videotapes of the Conference proceedings could serve as the focus for the meetings. Members of the Conference staff and Steering Committee will be available for consultation and assistance in directing the meetings.
2. To facilitate the enforcement of Title VII and VIII of the Public Health Service Act of 1971 prohibiting discrimination in health related training programs, *it is recommended that the Health Resources Administration prepare and distribute career guidance materials which: (a) promote the elimination of sex stereotyped roles in the health professions, (b) pay special attention to the interests and concerns of women applicants, and (c) provide information about costs and possible avenues of financial assistance.* As major consumers of health care, women should participate fully in the health planning process. *It is, therefore, recommended that programs and policies be developed which facilitate optimum involvement of women in implementation of the Health Planning*

and Resources Development Act of 1974 at Federal, State, and local levels.

3. *It is recommended that flexible health professional training programs which provide the opportunity for upward and lateral career mobility be encouraged by the Bureau of Health Manpower and that support services which would enable women to continue their education in the health field be provided.* Such support services include child care facilities, and leave systems for parenting.

It is further recommended that a national program be initiated to recruit and retain women, especially minority and economically disadvantaged women, in the health care professions and to provide special opportunities for minority and other disadvantaged women to be recruited to decisionmaking roles.

188 To implement this recommendation, the following strategies should be considered:

a. The encouragement of flexible training programs and continuing education programs for health professions and occupations.
b. The creation or expansion of support services, such as child care facilities at the place of work, leave systems for parenting, and flexible working schedules.
c. The provision of inservice education to all health workers at all levels. These education programs should be designed to enable workers to achieve a maximum level of performance and not be restricted to education within narrow definitions of job categories.

Recommendations to the Secretary, DHEW

1. *It is recommended that the Assistant Secretary for Health establish a special advisory board of predominantly women health workers and consumers to promote the development of policy, program, and research within PHS directed to improving the status of women in the heath sectors.*

The members should be representative of the various types of health care providers and consumers, and the group should be balanced in terms of minority status, age, and geographic location. Nominations for membership to the group should be solicited from the Women's Councils and offices within the Public Health Service as well as from various women's groups and health organizations. The board should consist of eight to twelve members. In addition, a representative of each of the Women's Councils and offices dealing with women's concerns at the agency level, plus each PHS agency FWP Coordinator, should be ex-officio members of the group. The Assistant Secretary for Health (ASH) advisory group's mission will be to present recommendations regarding policies, programs, and other actvities related to women and health to the Assistant Secretary, and to advise and assist the Assistant Secretary in implementing such recommendations.

The ASH advisory group will be the communications link between the Secretary's Advisory Committee on the Rights and Responsibilities of Women (SACRRW) and ASH and the PHS agencies, and will monitor the implementation of the SACRRW recommendations within the PHS agencies. The chairperson of the ASH advisory board shall be an ex-officio member of the SACRRW health subcommittee.

It is further recommended that the Assistant Secretary commit the resources and staff necessary to establish and maintain the advisory board. A full-time DHEW employee should be selected or designated as Executive Secretary to this committee, to be located within the Office of the Assistant Secretary for Health.

2. Women should be involved, even if only on an *ex femina* basis, at the highest levels of government and non-governmental organizations in formulating policies which impact upon health. Furthermore, DHEW should take a leadership role in fostering the representation and participation of women in health policymaking and advisory positions. Specifically, *it is recommended that DHEW stimulate an executive policy which would appoint women to all presidential and executive branch committees which advise the government on health concerns.* This policy would also assure that those committees which bear on the health concerns of women are composed of a majority of women.
3. *It is recommended that the Offices of the Assistant Secretary for Planning and Evaluation and the Assistant Secretary for Legislation initiate steps to ensure that in the planning and introduction of national health insurance legislation, as well as health manpower and training bills, the special needs of women as health care providers and consumers are addressed.* Specifically this means:
   a. Since an increasing number of women seek treatment by women health professionals, such as nurse-midwives and nurse practitioners, this treatment should be covered under any national health insurance system. In the meantime, Medicaid and Medicare should reimburse the services of these health professionals.
   b. National health insurance legislation should include prohibitions against unequal terms and conditions of coverage based on sex.
4. *It is recommended that the Office for Civil Rights conduct informational meetings in Washington, as well as the Regional Offices, to inform the health profession schools and the Bureau of Health Manpower about the impact of Title VII and VIII on Public Health Services agencies and its regulations on their current policies and activities. It is further recommended that the Secretary's Advisory Committee on the Rights and Responsibilities of Women review the Office for Civil Rights' enforcement of the anti-discrimination laws in the health training programs and inform the PHS agencies about the progress of the enforcement.*

The following petition was circulated at the Conference and was signed by a number of the Conference participants. The resolutions were developed from the petition by Helen Marieskind.

Many of us think that a statement reflecting the needs of women health workers and consumers must be made at this conference. We recognize that we represent the elite of the female health sector. Any discussion of changes in the health care system must include representation of the average women health workers. Nevertheless, we feel this is an opportune time to make the following statement.

Health care in the United States is subsidized by women. As workers, women are mostly underpaid, low paid and unpaid. As consumers, women and their families receive inadequate health care and do not even have a real voice in determining the policies of the health system.

Just slotting women into the present sexist, racist system is not enough. We want the health system restructured to provide adequate services, institutional power and decent pay.

The Government's responsibility to women transcends exploring different models for change. The Department of Health, Education, and Welfare is one of the most important agents shaping the health system today. Thus, we demand that DHEW put its money and muscle behind the following:

1. Free and total access to all methods of birth control and abortion.
2. DHEW commitment to new research to find a truly safe and effective contraceptive for both women and men.
3. The end to involuntary sterilization of women.
4. The end to uninformed and uncontrolled experimentation on all women, especially minority women.
5. Funds and projects concerning contraception and sterilization should be allocated by committees consisting only of women consumers and women health care workers at all levels. These committees must be given the same authority as any existing NIH funding committee.
6. Women-controlled health committees, instead of obstetricians or gynecologists should be responsible for DHEW policy for providing quality control over gynecological and obstetrical care.

7. DHEW funding should give priority to neighborhood health services controlled by neighborhood residents and health center workers. No further expansion of hospital-based services.
8. Demonstration clinics of many different types, including women's self-help clinics, should be funded.
9. Free access to all health services, for both chronic and acute care, regardless of ability to pay.
10. Women should not be expected to provide unpaid nursing services to spouses or relatives. Medicare and Medicaid funds should be available for in-home nursing care.
11. Preventive health care and health education should be the cornerstone of health policy—the way to decrease our dependence on expensive and exploitative health care. Services necessary for health maintenance and illness prevention must be stressed and the users of these services must be participants in rather than recipients of care. Therefore, health education must be a major function of all health workers.
12. Licensure laws and occupational classification should be changed to permit a wide variety of already skilled women workers to give primary health care, with decent salaries and decision-making powers. This is especially needed for women with knowledge and skills that are under-utilized and under-paid, and for those whose prior access to specialized education and training has been limited.
13. DHEW should fund local representative assemblies of women where further changes in the health system and hospital practices can be drafted. Resources should be supplied to women to gather necessary information for these assemblies. DHEW should employ its powers to ensure that the resulting recommendations are implemented.

June 17, 1975
International Conference on
Women in Health

From this statement

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare provide free and total access to all methods of birth control and abortion, with full information concerning each method supplied by the provider.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare has a commitment to new research to find a truly safe and effective contraceptive for both men and women. Uninformed and uncontrolled experimentation has created a hazard for women, especially minority women. Therefore, all research funds and projects should be allocated and overseen by committees consisting only of women consumers and women health care workers at all levels. These committees must be given the same
190 authority as any existing NIH funding committees.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare establish women-controlled health committees, which instead of obstetricians and gynecologists, should have responsibility for advising DHEW of policy for providing quality control over gynecologic and obstetric care.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare funding should give priority to neighborhood health services controlled by neighborhood residents and health centers. No further expansion of hospital-based services. Demonstration clinics of many different types, including women's self-help clinics, should be funded.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare must recognize that women cannot be expected to provide unpaid nursing services to spouses or relatives. Medicare and Medicaid funds should be available to reimburse providers of in-home nursing care. All persons should have free access to all health services, for both chronic and acute care, regardless of ability to pay.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare recognize that preventive health care and health education should be the cornerstone of health policy. Services necessary for health maintenance and illness prevention must be stressed and the users of these services must be participants in rather than recipients of care. Health education must be a major function of all health workers.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare must make efforts to change licensure laws and occupational classifications to permit a wide variety of already skilled women workers to give primary health care, with decent salaries and decisionmaking powers. This is especially needed for women with knowledge and skills that are under-utilized and underpaid, and for those whose prior access to specialized education and training has been limited.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare should fund local representative assemblies of women health workers at all levels of the system. In these assemblies further changes in the health system and hospital practices can be drafted. Resources should be supplied to women to gather necessary information for these assemblies. DHEW should employ its powers to ensure that the resulting recommendations are implemented.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare mandate midwifery programs within every public health department and within any service providing health care for women. That DHEW funding be withheld for failure to comply. Women's right to freedom of choice of provider must be insured.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare must encourage the building of day care centers (since 70% of health workers are women) by not providing Medicare and Medicaid and Maternal and Child Health funds to any health care institution that does not have a day care center for its employees.

BE IT RESOLVED THAT CONCERNING THE STERILIZATION OF PUERTO RICAN WOMEN:

Whereas the government of Puerto Rico through its spokesmen including Dr. Atono Silva, Assistant Secretary of Health for Family Planning, has stated the goal of increased number of sterilization of Puerto Rican women and

Whereas Puerto Rico is in the Department of Heatlh, Education and Welfare Region II and

Whereas the Department of Health, Education and Welfare has funded family planning in Puerto Rico including sterilization clinics and procedures and

Whereas at least 35% of women of childbearing age in Puerto Rico have already been sterilized

BE IT RESOLVED THAT THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE:

1. Censure such indiscriminate and massive use of sterilization procedure
2. Require that all family planning services be provided only within comprehensive health care centers
3. Promulgate more stringent guidelines than those of 1974 and require:
   a) That consent be obtained at times other than admission for childbirth and abortion
   b) That there be a mandatory thirty (30) day waiting period between consent and actual procedure
   c) That trial educational materials prepared by women consumer groups on the risks, advantages of various methods of birth control, including sterilization in various languages of the people of the United States be made available to all women and
   d) That statistics be compiled at a national

level and received at least twice a year to project whatever class, age or ethnic biases are occurring in sterilization procedure.

BE IT RESOLVED THAT:

Inservice education must be provided to all workers at all levels. These education programs must be designed to enable workers to achieve a maximum level of performance and not be restricted to education within narrow definitions of job categories. DHEW funding shall be withheld for failure to comply.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare provide primary health services for women through publicly funded programs. These services should be comprehensive in nature and not restricted to those services normally classified within the specialty of obstetrics and gynecology.

BE IT RESOLVED THAT:

The Department of Health, Education, and Welfare withhold funding from those health science schools which do not have active minority and women's admission and retention programs designed to admit minority and women students in the same percentage as they are reflected in society.

That funding be given to poor health science students without "strings".

That all health science students be required to give two years of service following graduation to health service shortage areas both rural and urban.

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Appendix

Conference Participants *

***This listing of conference attendees does not include last minute replacements, cancellations, and/or additions.**

SPEAKERS AND STEERING COMMITTEE MEMBERS

Aurora P. Asanza, M.D.
Assistant Dean, Dept. Pediatrics
University of the East
Ramon Magsaysay Memorial Med. Ctr.
College of Medicine
Aurora Boulevard
Quezon City, Philippines

Carol A. Brown, Ph.D.
Assistant Professor of Urban Studies
Queens College, CUNY
Flushing, NY 11367

Jean E. Campbell, D.D.S.
Discussant
532 W. Chapman Avenue
Placentia, CA 92670

Virginia Cleland, R.N., Ph.D.
Director of Graduate Studies
College of Nursing
Wayne State University
Detroit, MI 48202

Barbara Ehrenreich, Ph.D.
16 Walters Avenue
Syosset, NY 11791

Ellen T. Fahy, R.N., Ed.D.
Dean and Professor
School of Nursing
SUNY At Stony Brook
Health Sciences Center
Stony Brook, LINY 11794

Mark G. Field, Ph.D.
Professor of Sociology
Boston University
96 Commington St.
Boston, MA 02215

Teresa Orego de Figueroa
Consultant
Pan American Health Organization
525 23rd St., N.W.
Washington, DC 20037

Victoria Feodosyevna Fokina
Interpreter; Senior Teacher
Moscow State Pedagogical Institute
of Foreign Languages
Metrostroevskaya Street, 38
Moscow, USSR

Loretta C. Ford, R.N., Ed.D.
Dean & Director of Nursing
University of Rochester
260 Crittenden Boulevard
Rochester, NY 14642

Francoise Giroud
State Secretary for the Condition of Women
72 rue de Veronne
75700 Paris, France

Elina Haavio-Mannila, Ph.D.
Professor of Sociology
University of Helsinski
Institute of Sociology
Franzeninkatu 13
SF-00500 Helsinki, Finland

Elizabeth Harding, R.N.
Assistant Professor
School of Nursing
University of California, S.F.
San Francisco, CA 94143

Mary Howell, M.D., Ph.D.
Pediatrician
Box D
York Harbor, ME 03911

Jacqueline J. Jackson, Ph.D.
Associate Professor
Division of Medical Sociology
Duke Univ. Medical Center
P. O. Box 3003
Durham, NC 27710

Margot Jeffreys, B.Sc.
Professor
Bedford College, Univ. of London
Peto Place, Marylebone Road
London, NWa 4Dt England

Inga Johnsson
Assistant Head of Division
National Board of Health & Welfare
S-106-30 Stockholm
Sweden

Sumedha Khanna, M.D.
Chief, Planning & Evaluation Unit
Dept. of Family Health & Population Dynamics
Pan American Health Organization
525 23rd St., N.W.
Washington, DC 20037

Barbara A. Kivimae, B.A.
Program Analyst
Division of Planning, PHS, HRA, OPEL
Parklawn Building, Room 10A40
5600 Fishers Lane
Rockville, MD 20852

Zakhra kizi Kulieva, M.D.
Rector Azerbaydzan State Medical Institute
USSR
Bakikhanova Street, 23
Bakli, USSR

194 **Mary Ann Lewis,** R.N., M.S.
Project Director
Family Nurse Practitioner
Primex Program, UCLA
221 Burlingame
Los Angeles, CA 90049

Betty A. Lockett, Ph.D.
Conference Project Director
Division of Medicine
Bureau of Health Manpower
Health Resources Administration
National Institutes of Health DHEW
Building 31, Room 3C36
Bethesda, MD 20014

Ruth Watson Lubic, C.N.M., M.S.
General Director
Maternity Center Assn.
48 East 92nd St.
New York, NY 10028

Maricel Manfredi, R.N.
Head, Nursing Department
Division of Health
University of Valle, Colombia
Apartado 2188
Cali, Colombia

Helen I. Marieskind, M.P.H.
Assistant Professor of Health Sciences
SUNY at Old Westbury
Box 210
Old Westbury, NY 11568

Gladys E. Martin, M.B., B.S., M.P.H.
Associate Professor in Community
Medicine & Pediatrics
Yaounde, Cameroon
University Center for Health Science
B.P. 1364

Maggie Matthews, Dr. P.H.
Assistant Director for Special Programs
Office of Health Resources Opportunity
HRA, DHEW
Parklawn Building, Room 1035
5600 Fishers Lane
Rockville, MD 20852

Vicente Navarro, M.D.
Associate Professor, Health Care Organization
Johns Hopkins University
615 North Wolfe St.
Baltimore, MD 21205

Mary E. Patten
Federal Secretary
Royal Australian Nursing Federation
Suite 18, 33 Queens Road
Melbourne, Victoria
Australia

Angel Petros-Barvazian, M.D., D.C.H.
Chief, Maternal & Child Health
Division of Family Health
World Health Organization
1211 Geneva 27
Switzerland

Maria Dmitryevna Piradova
Chief Editor of Health Journal
USSR Ministry of Health
c/o Dr. Oleg Shchepin
Section on Foreign Relations
Rakhmanovski Per. D-3
Moscow I-51, USSR

Estelle Ramey, M.D., Ph.D.
Professor
Dept. of Physiology & Biophysics
Georgetown University
School of Medicine
3900 Reservoir Road, N.W.
Washington, DC 20007

Lillian Roberts
Associate Director
D.C. 37, AFSCME
140 Park Place
New York, NY 10007

Helen Rodriguez-Trias, M.D.
Director of Pediatrics
Albert Einstein Coll. of Medicine
Yeshiva University
Lincoln Hospital
333 Southern Blvd.
Bronx, NY 10454

Ruth Roemer, J.D.
Researcher in Health Law
School of Public Health, UCLA
University of California
Los Angeles, CA 90024

Darla J. Schecter
Assistant Conference Project Director
International Studies Staff
Division of Medicine, BHM/HRA/DHEW
National Institutes of Health
Building 31, Room 3C34
Bethesda, MD 20014

Jessie M. Scott, D.Sc., LHD
Assistant Surgeon General
Director, Div. of Nursing
BHRD/HRA
Federal Building
Room 5-16
7550 Wisconsin Avenue
Bethesda, MD 20014

Ruth Sidel
Author and Lecturer
3614 Johnson Avenue
Bronx, NY 10463

George A. Silver, M.D.
Professor of Public Health
Yale University, Sch. of Medicine
60 College Street
New Haven, CT 06510

Magdalena Sokolowska, MD, PhD, MPH
Professor of Medical Socioloty
Institute of Philosophy and Sociology
Polish Academy of Sciences
Nowy Swiat 72, Palac Staszica
00-330 Warsaw, Poland
Judith Ann Spelman, B.A., R.N.
Bay Area Negotiating Council
820 Ashbury St., #4
San Francisco, Ca 94110
Jeanne Spurlock, M.D.
Deputy Medical Director
American Psychiatric Association
1700 18th St., N.W.
Washington, DC 20009
Ms. Randi Tillman, B.A., D.M.D.
Dental Student
Univ. of Pennsylvania
3650 Chestnut Street
Box 190
Philadelphia, PA 19104
Betty M. Vetter, M.A.
Executive Director
Scientific Manpower Commission
1776 Mass. Ave., N.W.
Washington, DC 20036
Daniel F. Whiteside, D.D.S.
Director, Bureau of Health Manpower
HRA/PHS/DHEW
NIH, Bldg. 31, Room 5C-02
Bethesda, MD 20014
Nina B. Woodside, M.D., M.P.H.
Director
Center for Women in Medicine
Medical College of Pennsylvania
3300 Henry Avenue
Philadelphia, PA 19129
Eva Adams, J.D.
Consultant to Chairman of the Board
Mutual of Omaha
Omaha, NB 68131
Faye G. Adbellah, R.N., Ed.D., LL.D.
Assistant Surgeon General, USPHS
Chief Nurse Officer, PHS and Director
Office of Nursing Home Affairs
DHEW, PHS
Parklawn Bldg., Rm. 17B-07
5600 Fishers Lane
Rockville, Md. 20852
Linda H. Aiken, Ph.D.
Program Officer
The Robert Wood Johnson Foundation
P. O. Box 2316
Princeton, NJ 08540
Ruth K. Aladj, B.S.N., M.Ed.
Program Development Specialist
Office of Health Resources Opportunity
HRA, DHEW
Parklawn Building, Room 10-31
5600 Fishers Lane
Rockville, MD 20852
Ethel D. Allen, D.O.
Commissioner-I.W.Y.-Councilwoman
Commission on National Observance
of International Women's Yr.
582-B City Hall
Philadelphia, PA 19107

OTHER PARTICIPANTS

Geraldine Alpert, Ph.D.
Research Associate
Bureau of Applied Social Research
Columbia University
60J W115 St.
New York, NY 10025
Mrs. Patricia Amusa-Shonubi, M.P.H.
Special Assistant to the Deputy Director
Bureau of Health Manpower, HRA
NIH/Building 31, Room 5C02
9000 Rockville Pike
Bethesda, MD 20014
Dolores A. Ayers
Public Affairs Assistant
Office of the Secretary, DHEW
Room 5313 HEW North Bldg.
4th & Independence Ave., S.W.
Washington, DC 20201
Dr. Ruth Bacon
Director
U.S. Center, International Women's Year
1630 Cresent Place, N.W.
Washington, D.C. 20009
Senator Bill Brock
254 Russell Senate Bldg.
Washington, D.C. 20510
Jean L. Bainter, M.S.N.
Nurse Consultant
Division of Long-Term Care
HRA, National Center for Health
Services Research
Room 11A33, Parklawn Building
5600 Fishers Lane
Rockville, MD 20852
Perita Rodriguez Balian, M.S.W.
HEW Fellow-Special Assistant to Deputy
Director/HRA
5600 Fishers Lane
Rockville, MD 20852
Jacqueline Balk-Tusa, Ph.D.
Historical Consultant and IWY Liaison
National Women's Political Caucus
1921 Penn. Ave., N.W.
Washington, DC 20006
Shirley A. Barth, A.B.
Press Liaison Officer
Office of Public Affairs/PHS
5600 Fishers Lane, Room 17-22
Rockville, MD 20852
Rose Belmont, B.A., M.A.
Director
Multilateral Programs
Office of International Health, PHS
5600 Fishers Lane
Rockville, MD 20852
Judith Berek
Coordinator and Legislative Representative of
Health Profession
District 1199, RWDSU-AFL/CIO
National Union of Hospital and
Health Care Employees
310 W. 43rd St.
New York, NY 10036

Gila Berkowitz
Editor
Medical Dimensions
555 Madison Avenue
New York, NY 10022

Martha Blaxall, Ph.D.
Senior Professional Associate
Institute of Medicine
National Academy of Sciences
2101 Constitution Ave., N.W.
Washington, DC 20418

Maxine Bleich
Associate Program Director
Josiah Macy, Jr., Foundation
One Rockefeller Plaza
New York, NY 10020

196 **Julia Chang Bloch**
Representing Senator Percy
U.S. Senate
Washington, D.C. 20510

Alma Brown, B.A., M.A.
Program Specialist
Black Child Development Institute
1028 Connecticut Ave., N.W., Suite 520
Washington, D.C. 20036

Blanche B. Borkovic, B.A.
Promotional Officer
Women's Bureau, Dept. of Labour
Canada
Sir Wilfred Laurier Bldg.
340 Laurier Avenue West
Ottawa, Ontario K1A 0J2 Canada

Carol Brosgart, B.S.
Medical Student
Univ. of California, San Fran.
5855 Chabot Road
Oakland, CA 94618

Judith Brown, B.A.
Professional Relations Specialist
Bureau of Health Insurance, SSA
6401 Security Blvd.
Baltimore, MD 21235

Jennifer Burgess
Director
Women's Community Health Center
137 Hampshire St.
Cambridge, MA 02139

Susan Caghan, M.S.N.
Instructor in Phychiatric Nursing
Clinical Nurse Specialist
Adolescent Program
Yale-New Haven Hospital
Yale University
3106 LMP
New Haven, CT 06520

Ms. Patricia A. Cahill, B.A.
Director
Office of Long Term Care
Association of University Programs
in Health Administration
1755 Massachusetts Ave., N.W.
Washington, DC 20036

Mrs. June T. Caldwell, M.A.
Federal Women's Program Coordinator
National Institutes of Health
Room 2B34, Bldg. 31
9000 Rockville Pike
Bethesda, MD 20014

Ms. Margaret C. E. Cammaert, R.N., M.P.H.
Chief Nurse
Department of Special Technical Services
PAHO/WHO
525 23rd St., N.W.
Washington, DC 20037

Barbara R. Cantrill, B.A.
Consultant
149 Temple St.
West Newton, MA 02165

Eugenia S. Carpenter, M.P.P.
Asst. Research Scientist
School of Public Health
University of Michigan
Ann Arbor, MI 48103

Mrs. Susan L. Chaudry, B.S.N.
Nurse-Midwife Student
Georgetown University
10212 Rockville Pk. #202
Rockville, MD 20852

Marie A. Chavis, B.S.
Federal Women's Program Bureau Rep/OA
Health Resources Administration
5600 Fishers Lane, Room 10-46
Rockville, MD 20852

Violet O. Cherry, M.S.W., A.C.S.W.
Health Services Administrator
Englewood Health Dept.
20 South Van Brunt Street
Englewood, NJ 07631

June Jackson Christmas, M.D.
Commissioner
Dept. Mental Health/Retardation Svcs.
93 Worth St.
New York, NY 10013

Anne Harrison Clark
Women's Lobby
1345 G St., S.E.
Washington, DC 20003

Dottie Cook, B.S.
President
Job Market, Inc.
1816 Jefferson Place, N.W.
Washington, DC 20036

Patricia A. Cook, B.A.
Harvard Medical School
Joint Committee on the Status of Women
677 Huntington Ave., Room 324, HSPH
Boston, MA 02115

Verna Cook, Ph.D.
Program Development Specialist
Office of Health Resources Opportunity
HRA, DHEW
5600 Fishers Lane
Rockville, MD 20852

Jeanne A. Coombs, M.P.H., Dr. P.H.
Teaching Fellow
Project Director
National Study of Women in Dentistry
Harvard School of Public Health
677 Huntington Avenue
Boston, MA 02115

William H. Cope, M.D., M.P.H.
Special Assistant to Administrator
for International Affairs, HRA
Parklawn Building
Rockville, MD 20852

Kathleen A. Corless, M.S.N.
Assistant Coordinator
Metropolitan Washington Regional
Medical Program
2007 Eye St., N.W.
Washington, DC 20006

Jill S. Courduff, B.S.
Senior Medical Student
Co-President of Medical Student Council
Georgetown University
School of Medicine
3111 Hewitt Ave., #530
Wheaton, MD 20906

Sherman L. Cox, D.D.S., M.P.H.
Acting Director
Division of Dentistry
Bureau of Health Manpower
PHS, HRA, DHEW
9000 Rockville Pike
Bethesda, MD 20034

Toni D. Daniels, B.S.
SNMA Minority Women in
Medicine Chairperson
Student Nat'l. Medical Assn.
5012 Sargent Rd., N.E.
Washington, DC 20017

Anne J. Davis, Ph.D.
Associate Professor of Psychiatric Nursing
Univ. of Calif., S.F.
Parnassus Avenue
San Francisco, CA 94143

Virginia C. Davis
President
The Student National Medical Association, Inc.
2109 E St., N.W., Suite 400
Washington, DC 20037

Mary Brice Deaver, M.S.
State Health Coordinator
DHEW, PHS, Region VI
1114 Commerce St.
Dallas, TX 75202

Sigrid Deeds, M.P.H.
Assistant Professor
Department of Public Health Admin.
The Johns Hopkins University
School of Hygiene and Public Health
615 N. Wolfe St.
Baltimore, MD 21205

J. A. Deering
Acting Deputy Director, NIAA
National Institute on Alcohol
Abuse and Alcoholism, ADAMHA, DHEW
5600 Fishers Lane
Rockville, MD 20852

Thelma N. Domenici, M.S.
Assistant Executive Secretary (Health)
DHEW, Office of the Secretary
330 Independence Ave., S.W.
Washington, DC 20201

Beverly Witter DuGas, M.D.
Director
Health Manpower Planning Division
Health Manpower Directorate
Dept. of Health & Welfare
Brooke Claxton Bldg.
Tunney's Pasture (Room 1254)
Ottawa Canada K1A 1B4

Beth Duncan, M.S., M.P.H.
Health Services Representative
PHS, DHEW
50 Seventh St., Room 819
Atlanta, GA 30323

Ruth R. Greenberg Edelstein, R.N., Ph.D.
Associate Professor
Upstate Medical Center
SUNY at Syracuse
766 Irving Avenue
Syracuse, N.Y. 13210

Carolyn M. Elliott, Ph.D.
Director
Center for Research on Women in Higher
Education and the Professions
Wellesley College
Wellesley, MA 02181

Jo Eleanor Elliott, M.A.
Director of Nursing Programs
Western Interstate Commission for Higher Education
P.O. Drawer P
Boulder, CO 80302

Effie O. Ellis, M.D.
Special Assistant to the Executive Vice President
American Medical Association
535 North Dearborn St.
Chicago, IL 60610

Linda Feuer
Student
Empire State College
73 Lincoln Ave.
Ardsley, NY 10502

Robert Fischer, M.D.
Director
European Affairs
DHEW/PHS/OIH
Parklawn Room 18-75
5600 Fishers Lane
Rockville, MD 20852

June M. Fisher, M.D.
Robert Wood Johnson Clinical Scholar
350 Parnassus Ave., Suite 310
San Francisco, CA 94117

Mr. Robert L. Foster, B.A.
Equal Employment Opportunity Officer
CDC
1600 Clifton Rd., N.E.
Atlanta, GA 30333

Marian P. Fox
Special Assistant
Office of Scientific Affairs/HRA
5600 Fishers Lane, Room 10-11
Rockville, MD 20852

Alice B. Frazer, M.S.P.H.
National MEDIHC Coordinator
Division of Associated Health Professions
Bureau of Health Manpower, HRA, PHS
7550 Wisconsin Avenue
Bethesda, MD 20014

Ms. Millie Freeman, B.S.
Equal Employment Officer/BHM
HRA-Bureau of Health Manpower
9000 Rockville Pike, Bldg. 31 Room 5B3
Bethesda, MD 20014

Francelia Gleaves, B.F.A.
Staff Associate
Project on the Status and Education of Women
Association of American Colleges
1818 R St., N.W.
Washington, DC 20009

198 **Patricia Albjerg Graham,** Ph.D.
Dean
Radcliffe Institute
Professor, Harvard Univ.
3 James St.
Cambridge, MA 02138

Ms. Mary E. Gregory, B.S., M.G.A.
Program Specialist
DHEW, USPHS, Div. of
Quality & Standards
50—7th St., N.E., Rm. 860
Atlanta, GA 30323

Ms. Opal Goodridge, D.D.S.
Howard University College of Dentistry
600 W St., N.W.
Washington, DC 20059

M. Leah Gorman, Ed.D., R.N.
Chief
Graduate Education Section
Psychiatric Nursing Educ. Branch,
NIMH/ADAMHA
Room 9C-09 Parklawn Building
5600 Fishers Lane
Rockville, MD 20852

Susan R. Gortner, Ph.D., R.N.
Chief
Nursing Research Branch
Division of Nursing, DHEW
DHEW, BHRD, HRA, Division of Nursing
90000 Rockville Pike
Room 6A-14, Federal Bldg.
Bethesda, MD 20014

Shirley Grossman, M.D.
Medical Director
Montefiore Hospital Ambulatory Service
3455 Steuben Avenue
Bronx, NY 10467

Ellen M. Guy
Health Analyst
Metropolitan Washington Regional
Medical Program
2007 Eye St., N.W.
Washington, DC 20006

Jeannette V. Haase, Ph.D.
Director
Radcliffe Institute Programs in Health Care
77 Brattle St.
Cambridge, MA 02138

Michael J. Habib, B.A.
Deputy Country Officer for France
Department of State
2201 C St., N.W.
Washington, DC 20520

Ms. Jessie Halpern, B.S., M.A.
Federal Women's Program Coordinator
Health Services Administration
Room 14-18 Parklawn Building
5600 Fishers Lane
Rockville, MD 20852

Bernice Catherine Harper, MSW, MSc P.H.
Director
Division of Long-Term Care
Natl. Tr. Hlth. Svcs. Rsch, HRA
Parklawn Bldg. Room 11A-33
5600 Fishers Lane
Rockville, MD 20852

Maureen I. Harris, Ph.D., M.P.H.
Health Scientist Administrator
Fogarty International Center, NIH
31/2015, Rockville Pike
Bethesda, MD 20014

Ferdinand R. Hassler, M.D., M.P.H.
Associate Director for International Programs
The Staff College
NIMH
Parklawn Bldg., Room 11-103
5600 Fishers Lane
Rockville, MD 20852

Ruth Johnsson Hegyeli, M.D.
Acting Director
Office of Program Planning and Evaluation
National Heart and Lung Institute, NIH
Building 31, Room 5A27
Bethesda, Md. 20014

Shirley Hendsch, B.S., M.A.
Coordinator of International Womens Programs
Department of State
2201 C St., N.W.
Washington, DC 20520

Elizabeth Hilborn, R.N., M.S.
International Health Consultant
6902 Brennon Lane
Chevy Chase, MD 20015

David E. Hohman
Deputy Director
Office for Int'l. Affairs Mgmt., DHEW
330 Independence Ave., S.W.
Washington, DC 20201

Ms. Barbara Holland
Acting Director Africa and Middle East
DHEW/PHS/OIH
Parklawn Room 18-62
5600 Fishers Lane
Rockville, MD 20852

Ann Brooke Holt, D.V.M.
Deputy Director
Division of New Animal Drugs
Bureau of Veterinary Medicine
FDA, PHS, DHEW
5600 Fishers Lane
Rockville, MD 20852

Matina Horner, Ph.D.
President
Radcliffe College
10 Garden St.
Cambridge, MA 02138

Ann Hyde
Executive Director
American Nurses' Foundation, Inc.
2420 Pershing Road
Kansas City, MO 64108

Lee Hyde
House of Representatives
Committee on Interstate and Foreign Commerce
Room 2125, Rayburn House Office Bldg.
Washington, DC 20515

Barbara Y. Iba, B.S.N.
EEO Coordinator
National Institute of Dental Research
Building 30, Room 433
Bethesda, MD 20014

Mary Lee Ingbar, Ph.D., M.P.H.
Regional Consultant for Health Economics
PHS, DHEW
John F. Kennedy Federal Bldg.
Boston, MA 02203

Ms. Linda Ittner
c/o Congresswoman Patricia Schroeder
1131 Longworth HOB
Washington, DC 20515

Eileen M. Jacobi, R.N., Ed.D.
Executive Director
American Nurses' Association
2420 Pershing Road
Kansas City, MO 64108

Ada Jacox, R.N., Ph.D.
Professor of Nursing
University of Iowa
Iowa City, IA 52240

Ms. Judith Jaffe, M.S.
Education Specialist
DHEW/Office of Education
7th & D St., S.W., Room 5008-ROB
Washington, DC 20202

Evelyn K. Jenkins, R.N., M.S.
Regional Nursing Consultant
DHEW/PHS Region I
John F. Kennedy Federal Bldg.
Government Center
Boston, MA 02203

Anita Johnson, J.D.
Attorney
Public Citizen's Health Research Group
2000 P St., N.W.
Washington, DC 20036

Beverly Johnson, DDS
Howard University College of Dentistry
600 W St., N.W.
Washington, DC 20059

D. W. Johnson, M.D.
Regional Health Administrator
DHEW/PHS Region X
1321 2nd Ave.
Seattle, WA 98101

Ms. Amber B. Jones
Assistant Program Coordinator
Association of American Medical Colleges
One DuPont Circle, N.W., Suite 200
Washington, DC 20036

Joseph Kadish, Ed.D.
Associate Director for Professions Development
Division of Associated Health Professions
Bureau of Health Manpower, HRA
DHEW
7550 Wisconsin Ave., Room 510
Bethesda, MD 20014

Barbara E. Kaplan, B.A.
Vice President and Corporate Finance Officer
Sylvan J. Kaplan, Ph.D., P.A.
Suite 218 The Irene
4701 Willard Avenue
Chevy Chase, MD 20015

Sylvan J. Kaplan, Ph.D.
President
Sylvan J. Kaplan, Ph.D., P.A.
Suite 218 The Irene
4701 Willard Avenue
Chevy Chase, MD 20015

Ms. Marlyn Kefauver
Acting Director
Office of Americas
DHEW/PHS/OIH
Parklawn Room 18-75
5600 Fishers Lane
Rockville, MD 20852

Patricia Kellogg, B.A.
Student
U. of Maryland
School of Medicine
6201 Leeke Forest Ct.
Bethesda, MD 20034

Sally Kilby-Kelberg, B.S.
Health Writer, Columbia Univ.
Dept. of Health Education
Teachers College
New York City, NY

David A. Kindig, M.D., Ph.D.
Deputy Director
Bureau of Health Manpower
DHEW
Bldg. 31, NIH, Rm. 5C-02
9000 Rockville Pike
Bethesda, MD 20014

Mary Kindig
Montgomery County Area Agency on Aging
DHEW
9000 Rockville Pike
Bethesda, MD 20014

Mary E. King
President, Mary King Assoc. Inc.
Consultant, HEW Secretary's Cmt.
Rights of Women
Ctr. for Women Policy Studies
2000 P St., N.W.
Washington, DC 20036

B. Ann Kleindienst
Director
Office of Special Concerns
HEW, Office of the Secretary
Assistant Secretary for Planning and Evaluation
Room 3523 North Bldg.
330 Independence Ave., S.W.
Washington, DC 20002

Robert F. Knouss, M.D.
Director
Division of Medicine
Bureau of Health Manpower HRA, DHEW
9000 Rockville Pike
Bethesda, MD 20014

Riitta-Liisa Kolehmainen, M.D.,M.P.H.
Harvard School of Public Health
677 Huntington Avenue
Boston, MA 02215

200

Pat Kurtz, M.S.
Asst. Prof. Psych.
Mental Health Nursing
Texas Women's University
7322 Dominque Drive
Dallas, TX 75214

Dorothea M. Lang, C.N.M., M.P.H.
President
American College of Nurse-Midwives
100 Vermont Ave., N.W.
Washington, DC 20005

Mary C. Langlais
Federal Women's Program Representative
HRA/DHEW/National Center for
Health Services Research
5600 Fishers Lane
Rockville, MD 20852

Myra Lappin, M.P.H.
Instructor
Dept. of Family Practice
Univ. of Texas, Medical School
7703 Floyd Curl Drive
San Antonio, TX 78284

Elaine R. Lazaroff
Federal Women's Program Representative
Bureau of Health Manpower, HRA
9000 Rockville Pike
Bethesda, MD 20014

Milo D. Leavitt, Jr., M.D., M.Sc., M.P.H.
Director
Fogarty International Center, NIH
Bldg. 31, Room 2C-02
Bethesda, MD 20016

Sonia Leon, M.A.
Program Analyst
Office of Health Resources Opportunity
HRA/DHEW
5600 Fishers Lane
Rockville, MD 20852

Brigid Gray Leventhal, M.D.
Head
Chemiommunotherapy Section
Pediatric Oncology Branch
National Cancer Institute, NIH
9000 Rockville Pike
Bethesda, MD 20014

Beatrice N. Levine
Partner & Project Director
Urban and Rural Systems Associates
Pier 1 1/2
San Francisco, CA 94111

Ruth Loevinger, B.A.
Women's Equity Action League
799 National Press Building
Washington, DC 20004

Susan Weinberg Luria, B.A.
Staff Editor
American Hospital Assn.
One Farrague Square South
Washington, DC 20006

William A. Lybrand, Ph.D.
Associate Administrator for Scientific Affairs
HRA, DHEW
5600 Fishers Lane, Room 10-11
Rockville, MD 20852

Harold Margulies, M.D.
Deputy Administrator
Health Resources Administration
DHEW
5600 Fishers Lane
Rockville, MD 20852

Shirley Marks-Brown, M.D.
Consultant
Minority Women in Medicine
The Student National Medical Assn.
2109 E St., N.W., Suite 400
Washington, DC 20037

Betty Hosmer Mawardi, Ph.D.
Associate Professor of Medical Education
Research and Project Director
Career Studies
Case Western Reserve University
School of Medicine
2119 Abington Road
Cleveland, OH 44106

Ms. Carmen R. Mayml, M.S.
Deputy Assistant Secretary
Director, Women's Bureau
U. S. Dept. of Labor
2000 Constitution Ave., N.W., Room S30
Washington, DC 20210

Ms. Helen C. McCarron, M.A.
Program Analyst
Bureau of Health Manpower, HRA, DHEW
NIH, Bldg. 31, Room 3B-51
Bethesda, MD 20014

Marcia McCord
United States Senate
Washington, DC 20510

Thomas A. McDermott, D.D.S., M.P.H.
Acting Deputy Director
Division of Resource Development
PHS, DHEW
50 Seventh St., N.E., Room 831
Atlanta, GA 30323

Mrs. Annette McElhannon
Equal Opportunity Specialist
Center for Disease Control
1600 Clifton Rd., N.E.
Atlanta, GA 30333

Rose Anne McGarrity, M.A.
Associate Dean
Georgetown University
School of Nursing
3700 Reservoir Rd., N.W.
Washington, DC 20007

Kathleen McInerney, R.N.
National Coordinator-Nurses NOW Task Force
National Organization for Women
610 Worth St.
Pittsburgh, PA 15217

Ms. Patsy McLain
Federal Women's Program Representative
National Center for Health Statistics
Equal Employment Opportunity Office
5600 Fishers Lane
Room 8A-37
Rockville, MD 20852

Dorothy McMullan, Ed.D.
Director, Division of Nursing
National League for Nursing, Inc.
10 Columbus Circle
New York, NY 10019

Miss Sue Meads
Acting Chief
Systems Devel. & Quality Control Branch
National Center for Health Statistics
HRA, DHEW
5600 Fishers Lane
Rockville, MD 20852

W. Delano Meriwether, M.D.
Special Assistant to the Assistant
Secretary for Health, DHEW
330 Independence Ave., S.W.
Washington, D.C. 20201

Mrs. Pauline Miles, M.S.W.
Assistant Vice President for Program and Planning
National Health Council
1740 Broadway
New York, NY 10019

Barbara Cooper Miller, R.N.
Management Analyst
HRA/OA/Div. Mgt. Policy
5600 Fishers Lane
Rockville, MD 20852

Mary L. Mills, C.N.M., M.A.
Nurse Consultant
DCS, BCHS, PHS, HEW
7107 9th St., N.W.
Washington, DC 20012

Mildred Mitchell-Bateman, M.D.
Director
West Virginia Department of Mental Health
State Capitol
Charleston, WVA 25305

Ruth Mondschein, Ph.D.
Staff Assistant for Spec. Projects to the
Assistant Secretary for Education
DHEW
400 Maryland Ave., S.W., Room 3163
Washington, DC 20202

William G. Murphy
Vice President, Urban Affairs
Mutual of Omaha Insurance Co.
3301 Dodge St.
Omaha, NE 68131

Carol C. Nadelson, M.D.
Asst. Professor Psychiatry
Harvard Medical School
Beth Israel Hospital
Boston, MA 02115

Marcia Nesbitt
Health Planner
Georgetown University Community Health Plan
5125 MacArthur Blvd., N.W.
Washington, DC 20016

Elena O. Nightingale, M.D., Ph.D.
Resident Fellow
National Academy of Sciences
2101 Constitution Ave., N.W.
Washington, DC 20418

Judy Norsigian
Member
Boston Women's Health Book Collective, Inc.
Box 192
W. Somerville, MA 02144

Ms. Lou Northcutt, R.N., B.S.
Psychiatric Nurse Clinician
Dallas County Mental Health
and Mental Retardation Center
3605 Routh Street
Dallas, TX 75219

Deborah Oakley, M.P.H.
Chairperson
Standing Committee on Women's Rights
Amer. Public Health Assn.
1709 Pontiac Trail
Ann Arbor, MI 48105

Lucy D. Ozarin, M.D., M.P.H.
Program Development Officer
Div. of Mental Hlth. Svc. Programs
NIMH
5600 Fishers Lane
Rockville, MD 20852

Nancy Perlman
Acting Director—Program Develop.
AFSCME
1625 L St., N.W.
Washington, DC 20036

Susan Pistolesi, R.N., B.S.
Assistant National Coordinator
Nurses Now Task Force
NOW
332 N. Craig St.
Pittsburgh, PA 15213

Isabel B. Price, Ph.D.
Social Science Program Analyst
Office of Planning, Evaluation, and Leg.
HRA, DHEW
5600 Fishers Lane
Rockville, MD 20852

Carlota Rios Ruy-Perez, J.D.
Independent Researcher
Health Law & Admin. Medicine
5927 Onondaga Rd.
Bethesda, MD 20016

Beverley Rutzick
Coordinator—Menopause Center
San Francisco Women's Health Center
3789 24th St.
San Francisco, CA 94114

Mutya San Agustin, M.D.
Chief
Ambulatory Care Services
Morrisania City Hospital
1225-57 Gerard Ave.
Bronx, NY 10452

Constantina Safilios-Rothschild, Ph.D.
Professor of Sociology and Director,
Family Research Center
Wayne State University
127 Library Court
Detroit, MI 48202

202 **Kathy Sanders**
Medical Student
Medical College of Pennsylvania
Box 518
3300 Henry Avenue
Philadelphia, PA 19129

Ms. Becky L. Schergens, B.A.
Special Assistant to the Assistant
Secretary for Education
DHEW
4000 Maryland Ave., S.W., Room 3163
Washington, DC 20202

Elsa Schneider, M.S.
Senior Program Advisor
U. S. Office of Education
400 Maryland Ave., S.W., Room 3163
Washington, DC 20202

Mrs. Sandra Schmaltz
Program Analyst
HRA, DHEW
5600 Fishers Lane W.
Rockville, MD 20852

Eileen Shapiro
Senior Staff Associate
Joint Cmt. on Status of Women
Harvard Medical School
677 Huntington Ave., Room 324, HSPH
Boston, MA 02115

Victor W. Sidel, M.D.
Chairman, Dept. of Social Medicine
Montefiore Hospital
Albert Einstein College of Medicine
111 E 210 St.
Bronx, NY 10467

Mitzi B. Silver, B.S.
VISTA
590 Ellsworth Ave.
New Haven, CT 06511

Joseph G. Simanis
Health Economist
International Staff
Office of Research and Statistics
Social Security Administration
1875 Connecticut Ave., N.W., Room 323
Washington, DC 20009

Artemis P. Simopoulos, M.D.
Executive Secretary
Division of Medical Sciences
National Research Council
2101 Constitution Ave., N.W.
Washington, DC 20418

Clay E. Simpson, Ph.D.
Deputy Director
Office of Health Resources Opportunity
HRA, DHEW
5600 Fishers Lane
Rockville, MD 20852

Christie A. Smith, B.A.
2nd Vice President
DC Student Nurses' Assn.
10 Columbus Circle
New York, NY 10019

Elizabeth Reichert Smith, Ph.D., R.N.
Health Science Administrator
Div. Manpower & Training Prog.
NIMH/ADAMHA
9C09 Parklawn Bldg.
5600 Fishers Lane
Rockville, MD 20852

Ruth A. Smith, M.N.
Associate Professor
Division of Nursing
Univ. of Mass
Western Mass. Public Health Bldg.
Amherst, MA 01002

Jeanne C. Sinkford, D.D.S., Ph.D.
Dean-Elect, Howard Univ., Coll. of Dentistry
Amer. Assn. Dental Schools
600 W St., N.W.
Washington, DC 20012

A. Ruth Soumah, M.S.W.
Associate Director
Health Division
National Urban League, Inc.
500 East 62nd St.
New York, NY 10021

Melissa Sousley, B.A., M.D.
Chairperson
Women in Medicine
Amer. Medical Student Assn.
860 Clermont #302
Denver, CO 80220

Dorothy J. Stacey, B.A., M.A., M.P.H.
Program Director
International Education Branch
Fogarty International Center, NIH
9000 Rockville Pike
Bethesda, MD 20014

Barbara Starfield, M.D.
Professor
Johns Hopkins University Medical Institutions
601 N. Broadway
Baltimore, MD 21205

V. F. Stepanov, M.D.
USSR Embassy
1706 18th St., N.W.
Washington, DC 20009

Joan F. M. Steward, B.A.
Deputy Equal Employment Opportunity Officer
HRA/DHEW
5600 Fishers Lane
Rockville, MD 20852

K. Mary Straub, Ed.D., R.N.
Chief
Research and Development Branch
Division of Long-Term Care
HRA, National Center for Health Services Research
Room 11A33, Parklawn Bldg.
5600 Fishers Lane
Rockville, MD 20852

Janet A. Strauss, M.P.H.
Executive Director
Council on Education for Public Health
1015 18th St., N.W.
Washington, DC 20036

Hazal Swann, M.D.
Chairman
Community Health Section
National Medical Association, Inc.
2109 E St., N.W.
Washington, DC 20037

Ms. Carleen Talley
Legislative Assistant
Health Legislation, DHEW
330 Independence Ave., S.W.
Washington, DC 20201

Dr. Elizabeth Tidball
Executive Secretary
Cmt. on Education & Employment
of Women in Science & Engineering
Commission on Human Resources
National Research Council
2101 Constitution Ave., N.W.
Washington, DC 20418

Ira D. Trail, Dr. P.H.
Director
Division of Nursing
University of Massachusetts
Amherst, MA 01002

Antoinette M. Vanderwerf, Ph.D.
Chief
Health Systems Branch
DHEW, PHS, Region III
P. O. Box 13716
Philadelphia, Pa. 19101

Mrs. John F. Van Nostrand
Chief
Long-Term Care Statistics Branch
National Center for Health Statistics
HRA, DHEW
Room 9-41, 5600 Fishers Lane
Rockville, MD 20852

Henrietta Villaescusa
Community Participation Specialist
DHEW/HSA
Bureau of Community Health Services
Division of Clinical Services
5600 Fishers Lane
Rockville, MD 20852

Kathryn Wallace
Women's Bureau
Dept. of Labor
14th & Constitution Avenue, N.W.
Washington, DC 20210

Mary Roth Walsh, Ph.D.
Director
Project on Women Physicians
Harvard Univ.
Radcliffe Institute
3 James St.
Cambridge, MA 02138

Virginia Li Wang, Ph.D., M.P.H.
Associate Professor
Dept. of Pub. Hlth. Admin
Johns Hopkins University
615 N. Wolfe St., Room 1009
Baltimore, MD 21205

David A. Waugh
Assistant Director
International Labor Office
1750 New York Ave., N.W., Suite 330
Washington, DC 20036

Elizabeth Weiss
Medical Student
Case Western Reserve University Medical School
2320 Bellfield Rd.
Cleveland, OH 44106

Laura B. Weiss, M.A.
Career Counselor
Georgetown University
1316 36th St., N.W.
Washington, DC 20007

Susan Weiss
Director of Information
American Society of Allied Health Professions
One DuPont Circle
Washington, DC 20036

Sally Welsh
Director
Women's Community Health Center
137 Hampshire Street
Cambridge, MA 02139

Jean Ann Westler, B.A.
Chairperson
ADAMHA Women's Council,
DHEW, Room 15C26, Parklawn Bldg.
5600 Fishers Lane
Rockville, MD 20852

Dorothy E. Whalen, D.D.S.
Georgetown Univ. Dental School
1820 N Quinn St.
Arlington, VA 22209

Holman R. Wherritt, M.D., M.P.H.
Regional Health Administrator
DHEW, Region VII
DHEW/PHS
Kansas City, MO 64106

Anne M. Willcox
Director of Nursing for Ambulatory Care
State Univ. Hospital
750 East Adams St.
Syracuse, NY 13210

Charles L. Williams, Jr., M.D.
Deputy Director
PAHO/WHO
525 23rd St., N.W.
Washington, DC 20037

Kathleen Nies Williams, M.A.
Consultant to the Health Program
The Rand Corporation
1700 Main St.
Santa Monica, CA 90406

Jacqueline G. Wilson, B.A.
Program Officer
Bureau of Health Insurance
Social Security Administration
26 Federal Plaza
New York, NY 10007

Marjorie P. Wilson, M.D.
Director
Dept. of Institutional Development
Assn. of American Medical Colleges
1 Dupont Circle, Suite 200, N.W.
Washington, DC 20036

204

Beverly Winikoff, M.D., M.P.H.
Nutrition Specialist
The Rockefeller Foundation
111 West 50th St.
New York, NY 10020

Carol Winograd, M.D.
San Francisco Women's Health Center
855 14th St.
San Francisco, CA 94114

Joanne Fischer Wolf, M.S.S.
Consultant on Women and Health
PA. Dept. of Health, Southeast Region
1400 Spring Garden St., Room 1300
Philadelphia, PA 19130

Carolyn A. Woodard, M.A.
Federal Women's Program Coordinator
DHEW-Health Resources Administration
5600 Fishers Lane
Rockville, MD 20852

Laurence Wyatt
Special Assistant to the Secretary
for International Affairs/DHEW
330 Independence Ave., S.W.
Washington, DC 20201

Grace Wyshak, Ph.D.
Associate Professor of Public Health
Yale University
205 LEPH
New Haven, CT 06510

Alice M. Yohalem, M.A.
Research Associate
Conservation of Human Resources
Columbia University
1125 Amsterdam Avenue
New York, NY 10025

Camille Young, D.D.S., M.P.H.
Dental Director
Community Group Health Foundation, Inc.
1728 Verbena St., N.W.
Washington, DC 20012

Daniel I. Zwick
Associate Administrator for Planning,
Evaluation and Legislation
HRA, DHEW
5600 Fishers Lane, Room 10A-56
Rockville, MD 20852

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